

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					2. REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JOHN M. ACE					2a. DATE OF DEATH MONTH DAY YEAR 10 18 84 2b. HOUR 10:40 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 4, 1900 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Power & Light	
13a. STATE Florida		13b. COUNTY Palm Beach		13c. CITY OR TOWN Boynton Beach		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 138 N.W. 10th Court 33435	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Ace					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Utt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Marilyn Findlay		ADDRESS 817 Stag Way Ft. Washington, Md. 22744			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Dehydration Terminal CHF DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a diabetes									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-15 , 19 84 , to 10-18 , 19 84 , that (I) (we) lost saw the deceased alive on 10-18 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE William Kent Jurs DEGREE MD				22c. DATE SIGNED 10/19/84				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. FURST M.D.				22e. ADDRESS 11701 Livingston Rd., Ft. Wash. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-24-1984		23c. NAME OF CEMETERY OR CREMATORY Oakland		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Home Monroe Pennsylvania			
24. FUNERAL DIRECTOR Lee Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR OCT 23 1984		25b. REGISTRAR'S SIGNATURE Lelia Baidam Pandey			
NAME Old Alexander Ferry Rd., Clinton Md. 20735									

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DIARY

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201.

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BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR	
COLE		10 22 1984		5:40	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		Negro		MONTH DAY YEAR	
				3 9 1919	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
South Carolina		U.S.A.		67 YRS.	
9. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cheverly		Prince George's Gen. Hosp.			
13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS		13c. CITY OR TOWN	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2738 N 12th ST		19133	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		17. INFORMANT	
ELLIOT		Tossie		Catherine Fawcett	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES?		18b. SOCIAL SECURITY NO.		18c. DATE OF DEATH	
(YES, NO, OR UNKNOWN)		215-225-13		10-24-84	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)		Thoraco-abdominal trauma			
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).		Congestive heart failure			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR MONTH DAY YEAR		Driver of pick-up truck/auto collision.	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		road		STREET CITY OR TOWN COUNTY STATE	
				I-95 no. of Livingston Rd., Prince George's Md.	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant MEDICAL EXAMINER		10-24-84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Oct 29, 1984		Willow Spring BAPT Ch.	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY MEDICAL EXAMINER		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		Oct 20 1984			
Phillips G.H. 1721 N Monroe St.					

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Released by Dr Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 2 7 8

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH B AFFRON		2a. DATE OF DEATH MONTH DAY YEAR 10 15 84 2b. HOUR 7.30pm	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 15, 1897	
6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		8. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	10. CITY OR TOWN OF DEATH CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	12b. KIND OF BUSINESS OR INDUSTRY Census Bureau		
13a. STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Wallace R. Pyles	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice J. Adams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Helen A. Tait - Camp Springs, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory Arrest Congestive Heart Failure Possible Pulmonary Emboli		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia, Chronic indwelling Foley catheter			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/12, 1984, to 10/15, 1984, that (I) (we) last saw the deceased alive on 10/15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE M. Levine	22c. DATE SIGNED 10/15/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. LEVINE, M.D.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 19, 1984	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR OCT 23 1984	25b. REGISTRAR'S SIGNATURE P. Rodriguez
26. ADDRESS Old Alexander Ferry Road, Clinton, Maryland		27. ADDRESS 7801 Old Branch Ave, CLINTON, MD	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2. DATE OF DEATH			3. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST Frances Jean ALSTON			MONTH DAY YEAR October 21, 1984			1:47 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Black		MONTH DAY YEAR Sept. 7, 1945		39 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		U.S.A.				Prince George's MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham		Doctors' Hospital of Pr. Geo. Co.				Retired		Gov.	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE		
Maryland			PG		Seat Pleasant		5906 Burgundy Street 20743		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Edward Bobbitt			Vallie Alston						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			239 74 9551		Charlie Alston 5906 Burgundy Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ruptured aorta DUE TO, OR AS A CONSEQUENCE OF (b) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. hypertension DUE TO, OR AS A CONSEQUENCE OF (c) hypertension									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: multiple myeloma									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
10/17			multiple myeloma			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 10/17 to 10/20 19 84 , that (I) (we) lost saw the deceased alive on 10/17 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			22b. SIGNATURE Lewis H. Dennis			22c. DATE SIGNED 10/24/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
LEWIS H. DENNIS, M.D.			831 University Blvd. E., Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Oct. 25, 1984		Sandy Grove Cemetery		Henderson, North		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John Stewart			OCT 25 1984			W. L. Wilson			
Stewart Funeral Home-4001 Benning Road, NE.									

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 8 0	
1. DECEASED NAME (TYPE OR PRINT) <i>Walter W. Appelle Jr</i>							2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> MATED <input checked="" type="checkbox"/> <i>10-29-84</i>		2b. HOUR <i>8:00</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>1</i> DAY <i>19</i> YEAR <i>35</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>49</i> YRS.	7. IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MINS <i>0</i>	7c. DATE PRONOUNCED DEAD <i>10-29-84</i>	7d. HOUR <i>8:00</i>		7e. MINUTE <i>00</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Conn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i>					
10. CITY OR TOWN OF DEATH <i>FORT WASHINGTON</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>13105 Larkhall Circle</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>US Air Force</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr. George</i>		13c. CITY OR TOWN <i>Ft. Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>13105 Larkhall Circle 20744</i>			
14. FATHER'S NAME FIRST <i>Walter</i> MIDDLE <i>W.</i> LAST <i>Appelle, Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Stella</i> MIDDLE <i></i> LAST <i>Winoski</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>1958-1978</i>		17. INFORMANT <i>Patricia R. Appelle same as item 13</i>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>? P.M. 10-29-84</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Self-inflicted by hanging</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET <i>13105 Larkhall Circle</i> CITY OR TOWN <i>Tarleton</i> COUNTY <i>Pr. George's</i> STATE <i>Md.</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER		DATE SIGNED <i>10-29-84</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/31/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cemetery</i>				23d. LOCATION CITY OR TOWN <i>Arlington</i> COUNTY <i></i> STATE <i>Va.</i>			
24. FUNERAL DIRECTOR NAME <i>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 31 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH INSTRUCTIONS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				3. HOUR			
Reginald P. Ashton				10/24 19 84				P. M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
Male	Black	7-9-1936	48 YRS.			10/24 19		Prince George's County		P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
D.C.		U.S.A.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Landover				3502 Hubbard Road, #301				Construction		Building.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)											
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Prince George's		Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3502 Hubbard Road, #301			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Joseph D. Ashton				BESSIE LINDSEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				578-50-0733				MINA ASHTON - SAME AS #13 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:											
(b) <u>chronic myocardial disease.</u>										Years	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED			
				HOUR A.M. MONTH DAY YEAR				(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19				None			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
<i>John S. Rogers</i>				Deputy				10/24/84			
EXAMINER'S NAME				ADDRESS							
(TYPE OR PRINT)				John S. Rogers, M.D.				1919 Seminary Road Silver Spring, Montgomery, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
				10/30/84		LINCOLN MEM. CEM.		SUITLAND, P.G. Co. MD.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME				ADDRESS							
H.S. WASHINGTON				4925 BURROUGHS AVE, ALC.				OCT 25 1984			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH INSTRUCTIONS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 8 2	
1. DECEASED NAME (TYPE OR PRINT) Edith E. Austin										2a. DATE KNOWN OF DEATH Oct 5 1984	
3. SEX F	4. RACE W	5. DATE OF BIRTH Feb. 26 1910	6. AGE (IN YEARS LAST BIRTHDAY) 74	7. IF UNDER 1 YR. MONTHS 0 DAYS 0	8. IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Oct 5 1984		2b. HOME OF DEATH Princ Georges			
1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Princ Georges		MD.			
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods N.H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY US Govt.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10000 Brunswick Avenue 20903			
14. FATHER'S NAME Henry Austin				15. MOTHER'S MAIDEN NAME (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Gene Wilson-nephew- ADDRESS 19971 Rehoboth Beach, Del.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8880 Bronchial Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) 10 days DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture Rt. hip											
19a. DATE OF OPERATION 8.22.84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fract. Rt Hip						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8:22 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell in N.H.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N.H.		21f. LOCATION STREET Powder Mill Rd CITY OR TOWN Adelphi COUNTY Princ Georges STATE MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) ME		DATE SIGNED Oct 6, 1984		MEDICAL EXAMINER John S. Rogers, ME ADDRESS 1919 Seminary Road, S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-8-1984		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood COUNTY Pr. Georges STATE Md.					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home ADDRESS 11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR OCT 10 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon parts. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 2 8 2 8 3					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR PM					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Camille O. Aylsworth					SEPTEMBER 29, 1984				10:35 _M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 22, 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hairdresser		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed		
13a. STATE Maryland					13b. COUNTY P.G.		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-09-0711		17. INFORMANT ADDRESS Mrs. Mary C. Anglin Hyatts. Md. 20781						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Organic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>83</u> to <u>PRESENT</u> , 19 _____, that (I) (we) last saw the deceased alive on <u>9/12</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Louis A. Casas MD</u> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/30/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LUIS A. CASAS MD</u>					22e. ADDRESS <u>14201 LAUREL PK DR #221 LAUREL MD 20707</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 12, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS F. Casch's Sons F.H. P.A. Hyattsville, Maryland					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 15 1984 Julia Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 2 8 2 8 4			
1. DECEASED NAME (TYPE OR PRINT) Maggie Duncan BAILEY						2a. DATE OF DEATH MONTH DAY YEAR October 21, 1984				2b. HOUR 4:45 P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Aug. 25, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md.				13b. COUNTY P.G.		13c. CITY OR TOWN Capitol Hghts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7423 Calder Drive, 20743	
14. FATHER'S NAME FIRST MIDDLE LAST John Duncan						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Sumler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Md. Wendolyn Crockett/7423 Calder Dr. Cap Hghts					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Severe Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/12</u> , 19 <u>84</u> , to <u>10/21</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John B. Theobalds</i> M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/22/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Theobalds M.D.						22e. ADDRESS 9811 Mallard Dr., Laurel, Md. 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 10/23/84		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME MARSHALL FUNERAL HOME						4217 9th St., NW WASHINGTON, DC 20011		25a. DATE REC'D. BY REGISTRAR OCT 29 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified of the cause of death).

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 2 8 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES A. BARTHOLOMEW			2a. DATE OF DEATH MONTH DAY YEAR 10 08 84			2b. HOUR MIN. 9:10 AM				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 8 24 28		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.		
13a. STATE Maryland			13b. COUNTY Pr. George		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2311 Rosecroft Blvd. 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Bartholomew					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie R. Martin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Margaret V. Bartholomew same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Large cell lung cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 19 84 to Oct. 8 19 84 , that (I) lost lost saw the deceased alive on Oct 8 19 84 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) have did not view the body after death.										
22b. SIGNATURE Harvey Z. Kasper MD					DEGREE MD			22c. DATE SIGNED 10/8/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY Z. KASPER MD					22e. ADDRESS 6055 Belknap Rd. Hyattsville Md.					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 10/11/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.					25a. DATE REC'D. BY REGISTRAR OCT 11 1984		25b. REGISTRAR'S SIGNATURE Dawson-Robert			

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G. F. Lewis 6000 Knox Hill Dr., Knoxville, Tenn. 37918

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MAURICE MILTON BASCUE			2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 10 DAY 26 YEAR 84		2d. HOUR 19 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Jan DAY 6 YEAR 1913	6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fuel Operator	
13a. STATE Maryland		13b. COUNTY PG	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Theodore MIDDLE M. LAST Bascue		15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE Bell LAST Willingham		13e. STREET ADDRESS 7909 Marlboro Pike 20747	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-10-7147		17. INFORMANT Anna Bascue	
				ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE Diabetic enteric pluriotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		DATE SIGNED 10/26/1984	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 Oct 84	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery - Brentwood		23d. LOCATION CITY OR TOWN PG COUNTY Md STATE
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		Funeral Home Suitland, Md.		25a. DATE REC'D. BY REGISTRAR 10/30/84	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



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UNITED STATES

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28287

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Oscar		2a. DATE KNOWN OF DEATH ESTIMATED 10-4-84		2b. HOUR 10-5-84	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12-28-40	6. AGE (IN YEARS) LAST BIRTHDAY 43 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Middleburg, Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MORE CITY OR COUNTY OF DEATH Prince Georges	
9. CITY OR TOWN OF DEATH Suitland, Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Suitland	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Beale Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvina Artist		16. SOCIAL SECURITY NO. 576 44 0835	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 576 44 0835		17. INFORMANT ADDRESS Gloria Beale 2020 Brooks Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure due to chronic Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		DATE SIGNED 10-5-84	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/84		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
24. FUNERAL DIRECTOR NAME R.N. Horton Co.		ADDRESS 600-Kennedy St. N.W.		25a. DATE REG'D. BY REGISTRAR Oct 11 1984	
25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 2 8 8

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie A. Bell			2a. DATE OF DEATH MONTH DAY YEAR October 15, 1984		2b. HOUR 5:15P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 22 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales	12b. KIND OF BUSINESS OR INDUSTRY Dept. Store
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN College Pk.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph -- Dillon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catharine -- Corr		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 4813 ADDRESS Niagara Rd. Joan Wilson College Park Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIORESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b)

CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF

(c)

SEVERE CORONARY ARTERY DISEASE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c

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19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-1, 1979, to 10-15, 1984, that (I) (we) lost saw the deceased alive on 10-15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Christine De Lima	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-16-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE DE LIMA		22e. ADDRESS 14201 LAUREL PK DRIVE LAUREL MD 20810	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/19/84	23c. NAME OF CEMETERY OR CREMATORY Md. Natl. Mem. Pk.	23d. LOCATION Laurel, Maryland	STATE
24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME INC. ADDRESS 7601 Sandy Spring Rd. Laurel Md. 20707		DATE REC'D. BY REGISTRAR OCT 18 1984		
25b. REGISTRAR'S SIGNATURE J. A. WARDEN				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5877.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 2 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILAGROS BELTRAN			2a. DATE OF DEATH MONTH DAY YEAR OCT 8 84			2b. HOUR 1:55p M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 20, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spain		7b. CITIZEN OF WHAT COUNTRY? Spain		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10. CITY OR TOWN OF DEATH Andrews Air Force Base		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow U.S. A.F. Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Andrews Air Force Base		13d. STREET ADDRESS / ZIP CODE 4231 B Gary Court (20335)		
14. FATHER'S NAME FIRST MIDDLE LAST Lorenzo Beltran				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aurelia Sirvent					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Margarita Bowks, Same As #13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>X Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>X Intraventricular Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>X 5 Oct</u> to <u>X 8 Oct</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8 Oct</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>X Carol A. Rupe MD</u>			22c. DATE SIGNED					22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>X Carol A. Rupe MD</u>			22f. ADDRESS Family Practice Resident AFSC 9341A 183-54-6249 Malcolm Grow USAF Med Ctr						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE October 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Maryland		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			24b. ADDRESS Old Alexander Ferry Road, Clinton, Maryland			25. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 007 15 1984			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

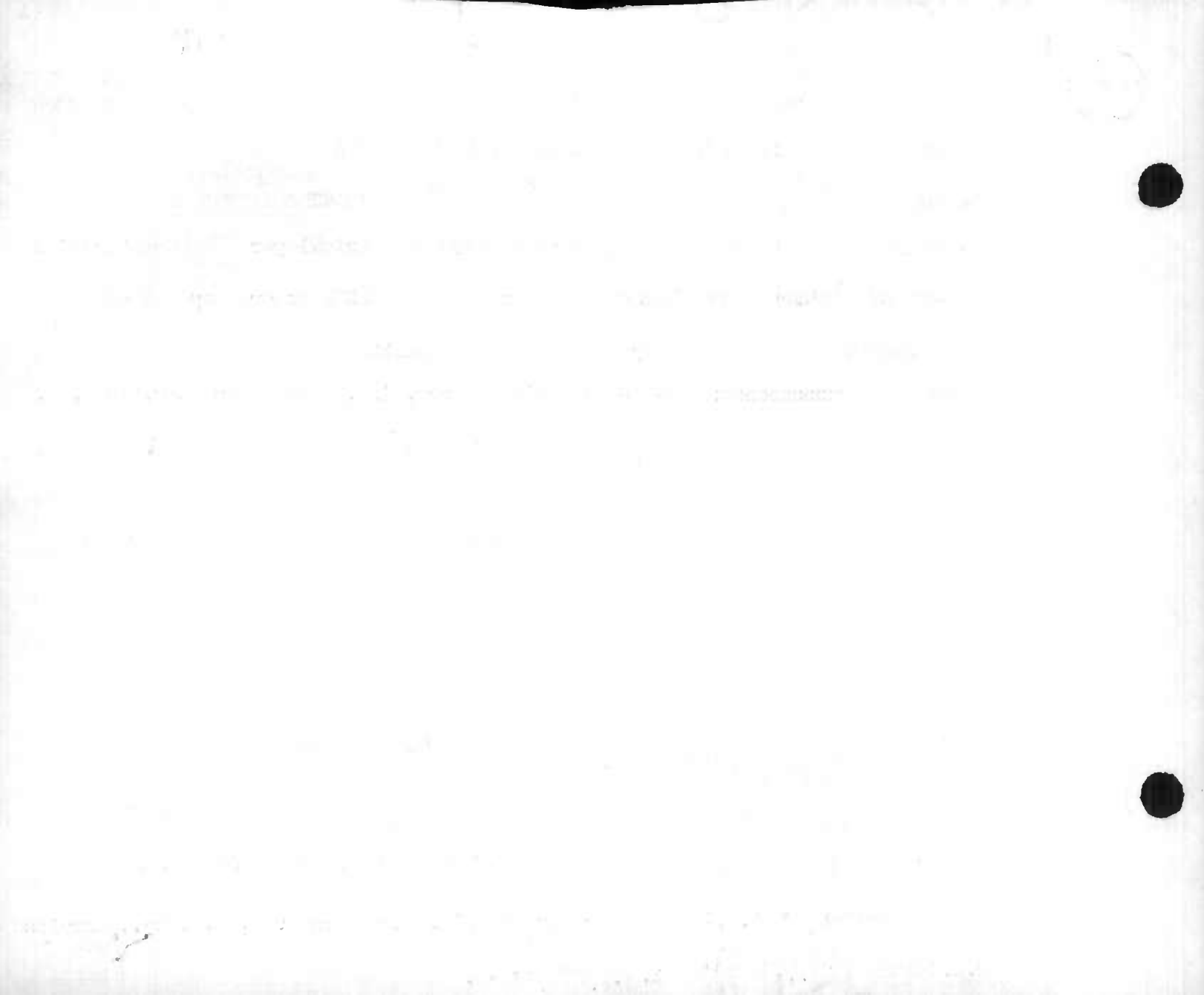
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				2 8 2 9 0			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM E. BERRY				2a. DATE OF DEATH MONTH DAY YEAR 10-02-84			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 19, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Prince George Largo		13c. CITY OR TOWN Largo	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Berry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Burnette			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) XXXXXXXXXX 124-34-5368		17. INFORMANT ADDRESS Viola Berry, Wife, 10025 Campus Way, Largo, Md. 20840			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pancreatic carcinoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>6 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/6</u> 19 <u>84</u> , to <u>10/2</u> 19 <u>84</u> , that (I) (we) lost <u>10/1</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (saw) (did not see) the body after death.							
22b. SIGNATURE <u>Lisa Goldberg</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>10/2</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LISA GOLDBERG, M.D.				22e. ADDRESS 2121 PENN. AVE. WASHINGTON, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 5, 1984		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, P.G. Cty. Maryland	
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO., 517 11th St. S.E.				24e. ADDRESS 20003 Wash., D.C.			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

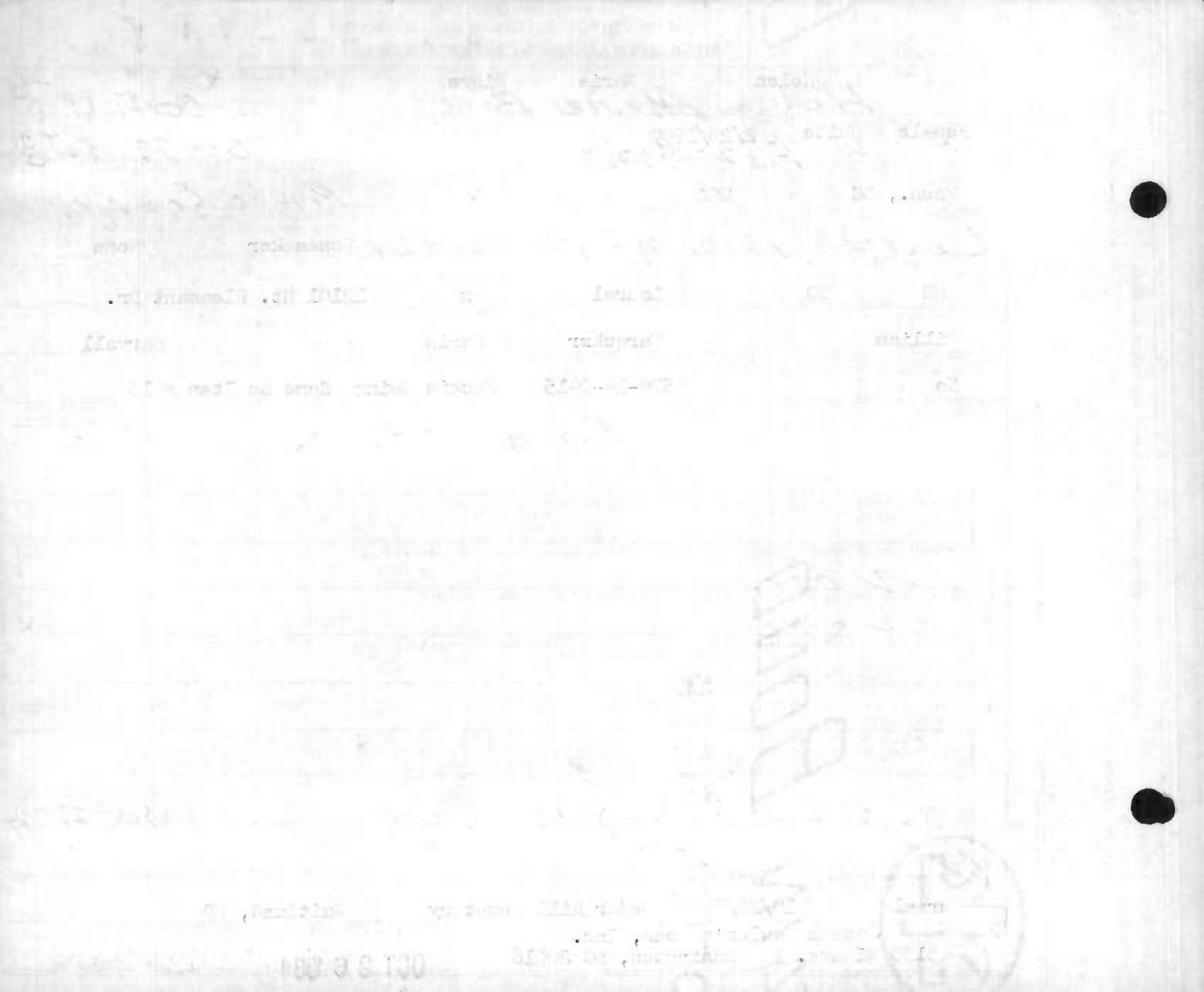
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH


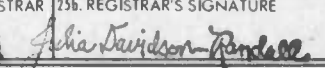
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			20. DATE KNOWN OF DEATH			21. DATE OF DEATH		
FIRST Helen MIDDLE Marie LAST Biggs			MONTH DAY YEAR			MONTH DAY YEAR		
2. SEX Female			4. RACE White			5. DATE OF BIRTH		
6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 24 HRS.			8. UNDER 24 HRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			13. CITY OR TOWN			14. INSIDE CITY LIMITS?		
15. STATE			16. COUNTY			17. STREET ADDRESS		
18. FATHER'S NAME			19. MOTHER'S MAIDEN NAME			20. ADDRESS		
21. WAS DECEASED EVER IN U.S. ARMED FORCES?			22. SOCIAL SECURITY NO.			23. INFORMANT		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			25. IMMEDIATE CAUSE (a)			26. DUE TO, OR AS A CONSEQUENCE OF		
27. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			28. DATE OF OPERATION			29. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
30. EXTERNAL CAUSE WAS			31. TIME OF INJURY			32. HOW INJURY OCCURRED		
33. UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			34. PLACE OF INJURY			35. LOCATION		
36. INJURY OCCURRED			37. PLACE OF INJURY			38. LOCATION		
39. I certify that I took charge of the remains described above, held an			40. Autopsy			41. Inspection		
42. death resulted from:			43. Natural causes			44. Accident		
45. ACTUAL SIGNATURE			46. TITLE (SPECIFY)			47. MEDICAL EXAMINER		
48. EXAMINER'S NAME			49. ADDRESS			50. DATE		
51. BURIAL, CREMATION, REMOVAL			52. DATE			53. NAME OF CEMETERY OR CREMATORY		
54. LOCATION			55. CITY OR TOWN			56. COUNTY		
57. FUNERAL DIRECTOR			58. NAME			59. ADDRESS		
60. DATE REC'D. BY REGISTRAR			61. REGISTRAR'S SIGNATURE			62. DATE		

OCT 26 1984



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) John N.M.I. Biondi						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> Sept. 18, 1984		MONTH DAY YEAR		4.52 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1- 4 1920	6. AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD September 18, 1984	MONTH DAY YEAR		4.52 P. M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Mt. Rainier		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3502 Newton Place # 4			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hotel Worker		12b. KIND OF BUSINESS OR INDUSTRY Hay-Adams			
13a. STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3502 Newton Place # 4		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 579-10-5216		17. INFORMANT ADDRESS Evelyn M. Biondi - Wife Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): None										
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy MEDICAL EXAMINER						DATE SIGNED 9/19/84		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-21-1984		23c. NAME OF CEMETERY OR CREMATORY Md. Vets. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Geo. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gaschs Sons, P.A. Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR OCT 16 1984		25b. REGISTRAR'S SIGNATURE 				

October 18, 1974

10-11-15-1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

OHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Sarah MIDDLE Lucile LAST Bird		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY 8-12-1908		6. AGE (IN YEARS) (LAST BIRTHDAY)		7. IF UNDER 1 YR. IF UNDER 24 HRS.	
7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR		10-28-84		1984	
7d. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2e. HOUR		10-28-84		1984	
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7f. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Pennsylvania		US				Baltimore			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bowie		Bowie Health Center		Retired		Education			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
W. Virginia		Mercer		Princeton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		906 Straley Avenue 24740	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		234-64-6499		Evelyn Bird Freshman		same as 13e	
Charles Robert Dunlap		Ella Philips							
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		234-64-6499		Evelyn Bird Freshman		same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)			
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
(b)		(b)		(b)		(b)			
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF			
(c)		(c)		(c)		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		DATE SIGNED			
Augusto P. Rodriguez		M.D. Deputy		MEDICAL EXAMINER		MEDICAL EXAMINER		10-28-84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		5009 Rayburn Ct., Temple Hills, Md.		5009 Rayburn Ct., Temple Hills, Md.			
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, Md.		5009 Rayburn Ct., Temple Hills, Md.		5009 Rayburn Ct., Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		Oct 30 1984		Keyser-Bryant Crematory		Beckley, West Virginia			
24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Beall Funeral Home		16000 Annapolis Road Bowie, Maryland 20715		NOV 2 1984		Julia Davidson-Randall			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

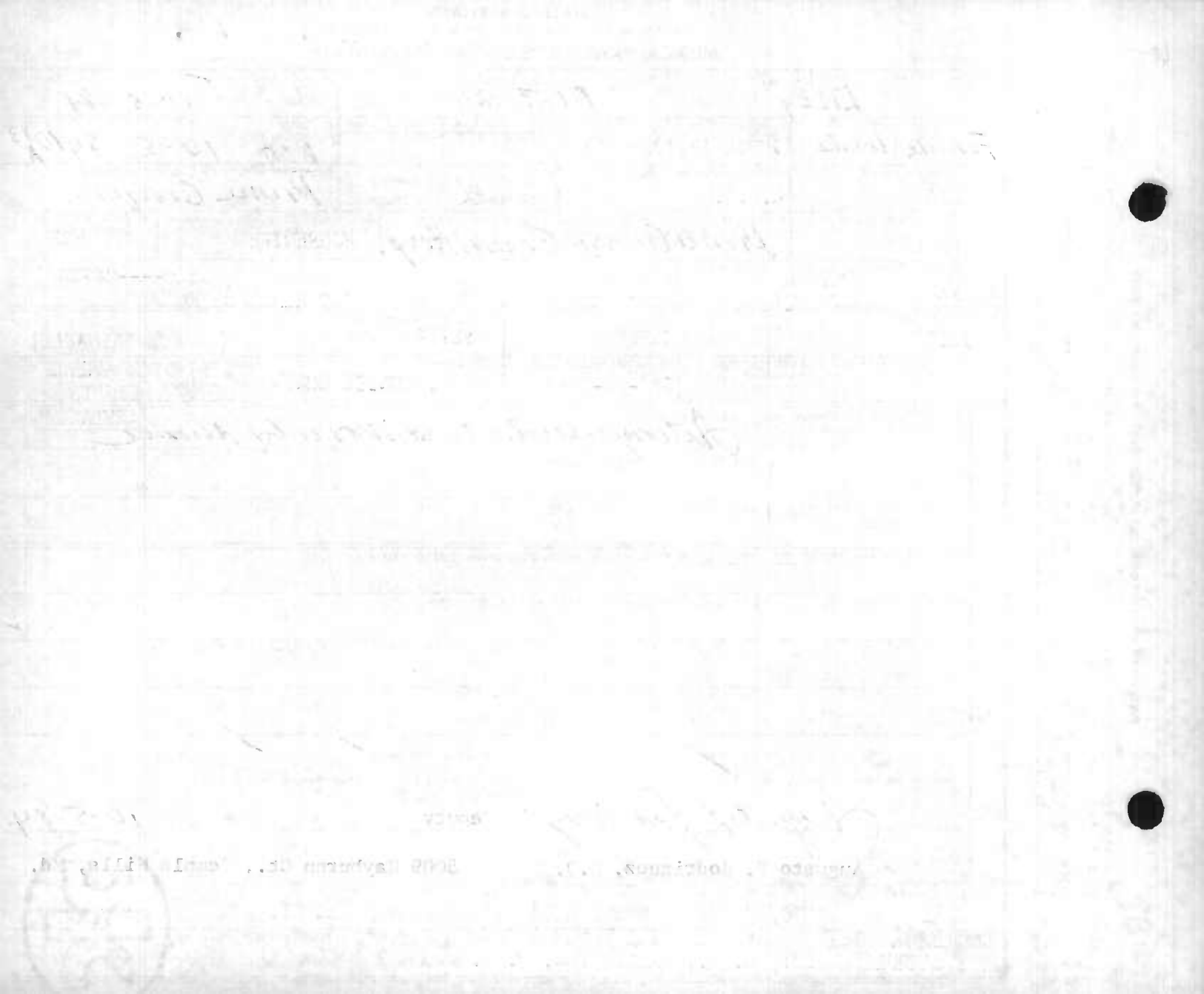
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST LIBBY MIDDLE BIRTMAN LAST BIRTMAN		2a. DATE KNOWN OF DEATH		MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		2b. HOUR	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH APRIL DAY 15 YEAR 1907		6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. CITY OR COUNTY OF DEATH Prince Georges		10. DATE PRONOUNCED MONTH 10 DAY 5 YEAR 1984	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		13. STREET ADDRESS 6 G RESEARCH ROAD	
13a. STATE MARYLAND		13b. CITY OR TOWN GREENBELT		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. ZIP CODE 20770		14. FATHER'S NAME FIRST PHILLIP MIDDLE KASTEN LAST YETTA	
14. FATHER'S NAME FIRST PHILLIP MIDDLE KASTEN LAST YETTA		15. MOTHER'S MAIDEN NAME FIRST YETTA MIDDLE (UNASCERTAINABLE) LAST (UNASCERTAINABLE)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 524-50-2759		17. INFORMANT ADDRESS 8418 57th AVENUE, BERWYN HEIGHTS, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER				DATE SIGNED 10-5-84	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/9/1984		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN DELPHI COUNTY PRINCE GEORGE'S STATE MARYLAND			
24. FUNERAL DIRECTOR DONALD M. STEIN		HEBREW MEMORIAL FUNERAL HOME ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25. DATE REC'D BY REGISTRAR OCT 11 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

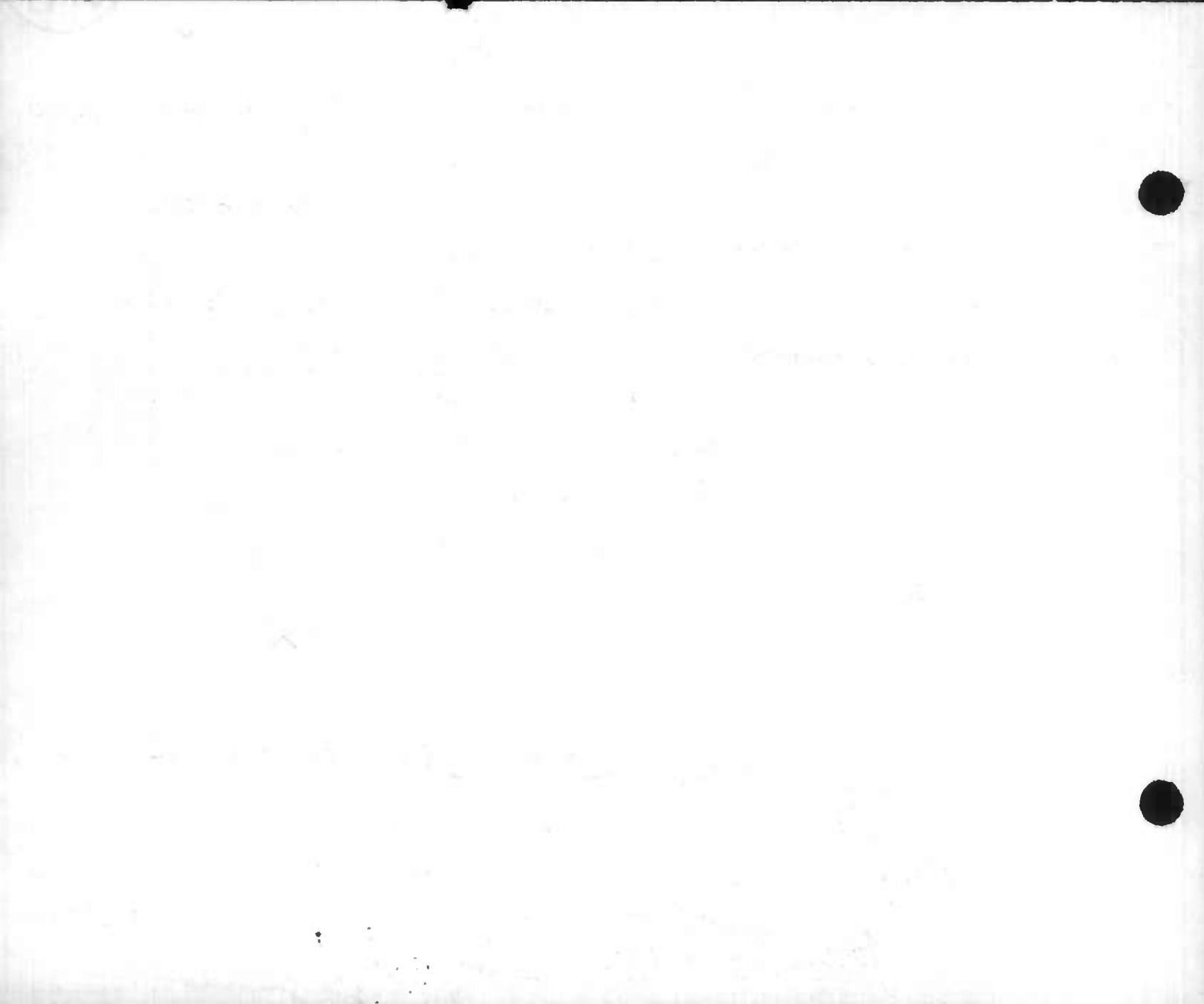
28295

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JULIA J. BOSTIC			2a. DATE OF DEATH MONTH DAY YEAR 10-24-84		2b. HOUR 5:50AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR April 10, 1893	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY PG	13c. CITY OR TOWN Capitol Heights	13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Reeves Jefferson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Aylett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 193 38 2229	17. INFORMANT 7028 Canyon Drive Mrs. Georgie Jennings-niece-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia and Congestive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Previous cerebrovascular Accident</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 5</u> 19 <u>84</u> , to <u>Oct 24</u> 19 <u>84</u> , that (I) (was) last saw the deceased alive on <u>Oct 23</u> 19 <u>84</u> , and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above, (I) (do) (did not) view the body after death.					
22b. SIGNATURE <u>M. Karim</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOBARAK KARIM		22e. ADDRESS LANDOVER MALL WEST, LANDOVER, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 30, 1984	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	23d. LOCATION CITY OR TOWN COUNTY Cemetery Suitland		
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, NE.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

BP

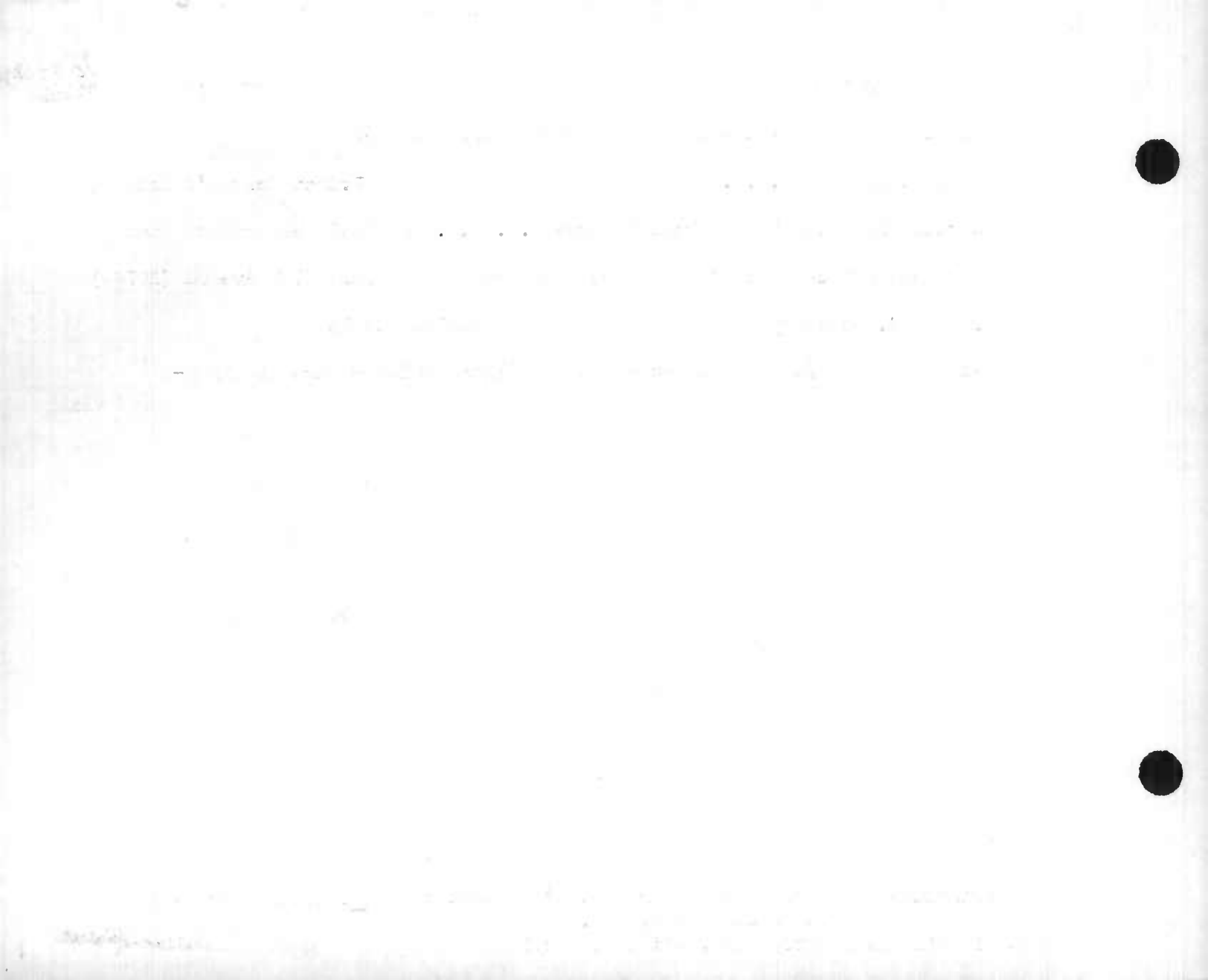


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOYCE S BOWLES				2a. DATE OF DEATH MONTH DAY YEAR OCT 30 1984				2b. HOUR 10:34 PM 2234 PM			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 25, 1934		6. AGE (IN YEARS (LAST BIRTHDAY)) 50 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.					
10. CITY OR TOWN OF DEATH Andrews Air Force Base		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow U.S. A.F. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hospital Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6228 87th Avenue (20784)			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas H. Sansbury				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Steele							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS William Bowles - Same As #13 A-E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <u>30 OCT</u> , 19 <u>84</u> , to <u>30 OCT</u> , 19 <u>84</u> , that (b) (we) last saw the deceased alive on <u>30 OCT</u> , 19 <u>84</u> , and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald W Rumbach				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 30 Oct 84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D RUMBAUGH				22e. ADDRESS MGMC							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE November 3, 1984		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Maryland			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. 16633 Old Alexander Ferry Road, Clinton, Maryland						25a. DATE REC'D. BY REGISTRAR NOV 9 1984		25b. REGISTRAR'S SIGNATURE John Davidson			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2 8 2 9 1	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Joseph W. Boyd					2a. DATE OF DEATH MONTH DAY YEAR 10 04 84			2b. HOUR 12:45Am			
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE, GIVE STREET ADDRESS) Souther Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY PRINCE GEORGES CITY OR TOWN CLINTON				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 2339 Green Street, S.E. 99999					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Boyd, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elous Matilda Woodward							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 577 44 6700		17. INFORMANT ADDRESS Jean C. Boyd-wife-2339 Green St. SE.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) esophageal carcinoma with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) diffuse Pulmonary Metastasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks 2 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 12 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9015 Woodyard Rd. Clinton, Md.							
22a. I certify that (I) (this hospital) attended the deceased from 8/22/84 to 10/4/84 , that (I) (we) last saw the deceased alive on 10/3/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE U. Mani		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-5-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U. MANI M.D.		22e. ADDRESS 9015 Woodyard Rd. Clinton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.					
24. FUNERAL DIRECTOR NAME Stewart		DATE REC'D. BY REGISTRAR 11 1984		REGISTRAR'S SIGNATURE Julia Davidson-Randall							

1

Respectfully,
Sincerely,
[Signature]

10/10/01

10/10/01

10/10/01

X

10/10/01

Items 13c-e per ph. 11/8/84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

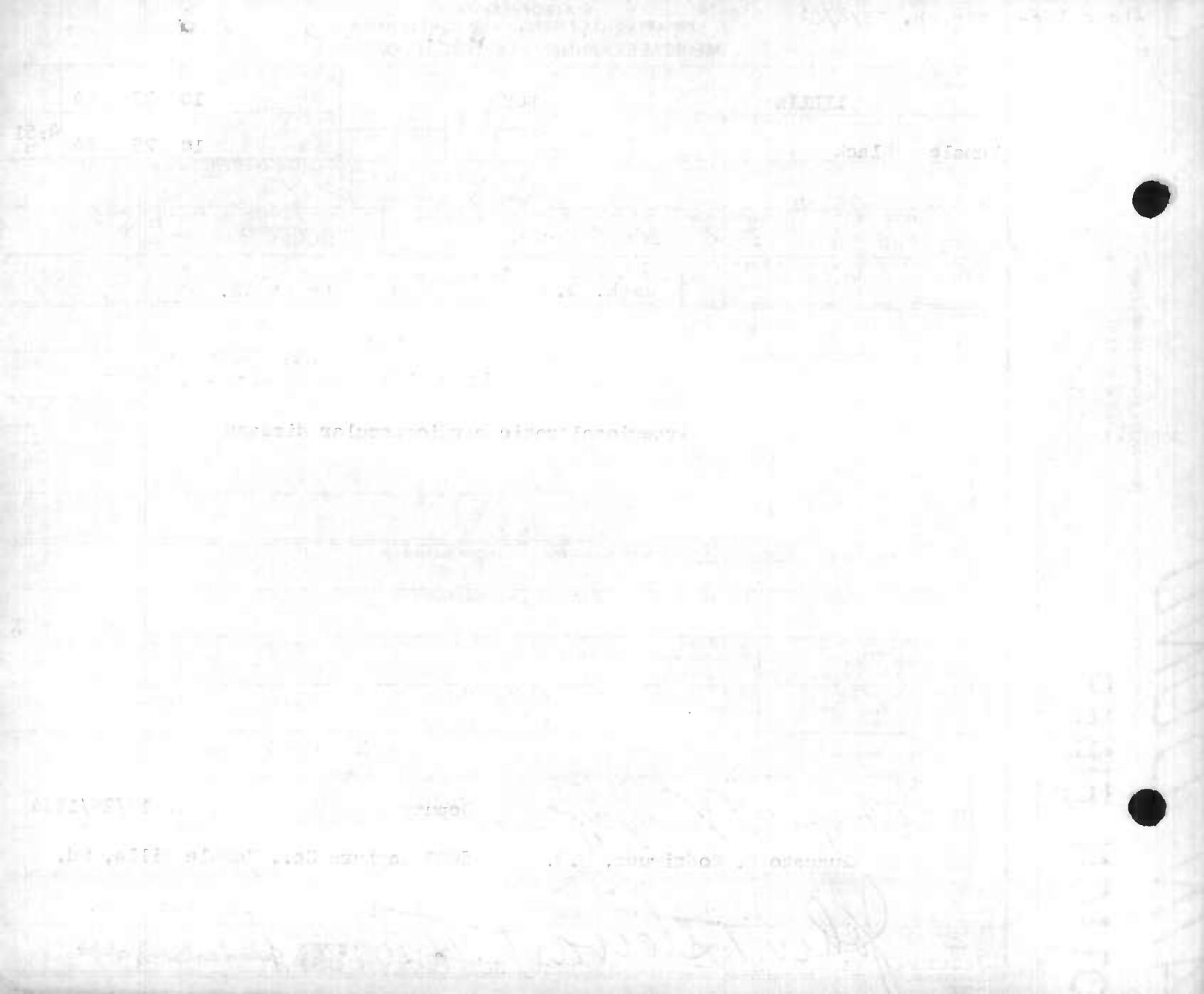
REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		LILLIE BOYD		10 25 19 84	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	2d. HOUR
Female	Black	July 14, 1899	85			10 25 19 84	4:51 p.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
North Carolina	USA				PG		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland	Prince George Hosp.		Housewife				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
47			wash. D.C.	YES <input type="checkbox"/> NO <input type="checkbox"/>	A Street SE. 99999		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Tom Grier				Laura Ray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
no		244 03 6174D		541 Thayer Avenue Ernestine Gregory-daughter-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		DATE	
Augusto P. Rodriguez		Deputy		10/26/1984		SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Oct. 30, 1984		Maryland National		Laurel, Maryland	
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Stewart Funeral Home-4001 Berning Road, N.E.		Nov 07 1984		John Davidson-Rodella			

BP

PHAN 17
WR 15 ME 151
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Paul BRAHLER		2a. DATE KNOWN OF DEATH ESTIMATED 10-5-84		2b. HOUR 8:45	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7-27-12	6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 10-6-84
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6560 Beechwood Drive	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fire Inspector-Ret.		12b. KIND OF BUSINESS OR INDUSTRY D.C. Fire Dept		12c. ADDRESS 20748	
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Camp Springs	
14. FATHER'S NAME FIRST MIDDLE LAST John Brahler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 579-10-6303		17. INFORMANT Barbara B. Brahler		17a. ADDRESS 6560 Beechwood Dr. Camp Springs, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 10-6-84	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/84		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	
23d. LOCATION CITY OR TOWN Clinton		COUNTY P.G.		STATE Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR OCT 11 1984	
25b. REGISTRAR'S SIGNATURE Davidson					

George I. Kales (Kale's Home) Oxon Hill, Md.
 10/9/51 Reurrection Cemetery Clinton E.G. Maryland
 10/9/51 Reurrection Cemetery Clinton E.G. Maryland

No 279-10-6303 Barbara E. Branley 5560 Beechwood Dr.
 John Branley Unknown Unknown

Maryland Prince George's Camp Springs x 6560 Beechwood Drive
 Camp Springs Washington, D.C. U.S.A.
 Prince George's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					2 8 3 0 0 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
Arthur C Brittingham					October 9, 1984				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)		7b. HOUR	
Male		White		MONTH DAY YEAR		74 YRS.		6:00p	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
PA		USA				Prince George's Co. MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Suitland		4208 Skyline Dr Suitland Md				Eng. U.S. Govern.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE			
MD		PG		Suitland		4208 Skyline Drive 20746			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Arthur C Brittingham					Hettie (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					182-09-5139		Gail Brittingham Same as #13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstructive Pulmonary Disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i> <i>3 yrs.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic Obstructive Pulmonary Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov.</i> , 19 <i>65</i> , to <i>10-9</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>10-9</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frank S. Pellegrini MD</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>10-10-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank S. Pellegrini					22e. ADDRESS 3611 Branch Ave. Hillcrest Hgts Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Cremation		10/10/84		Cedar Hill Crematory		Suitland PG		MD	
24. FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home MD OCT 17 1984 <i>John Davidson-Randall</i>									

BP _____



RECEIVED



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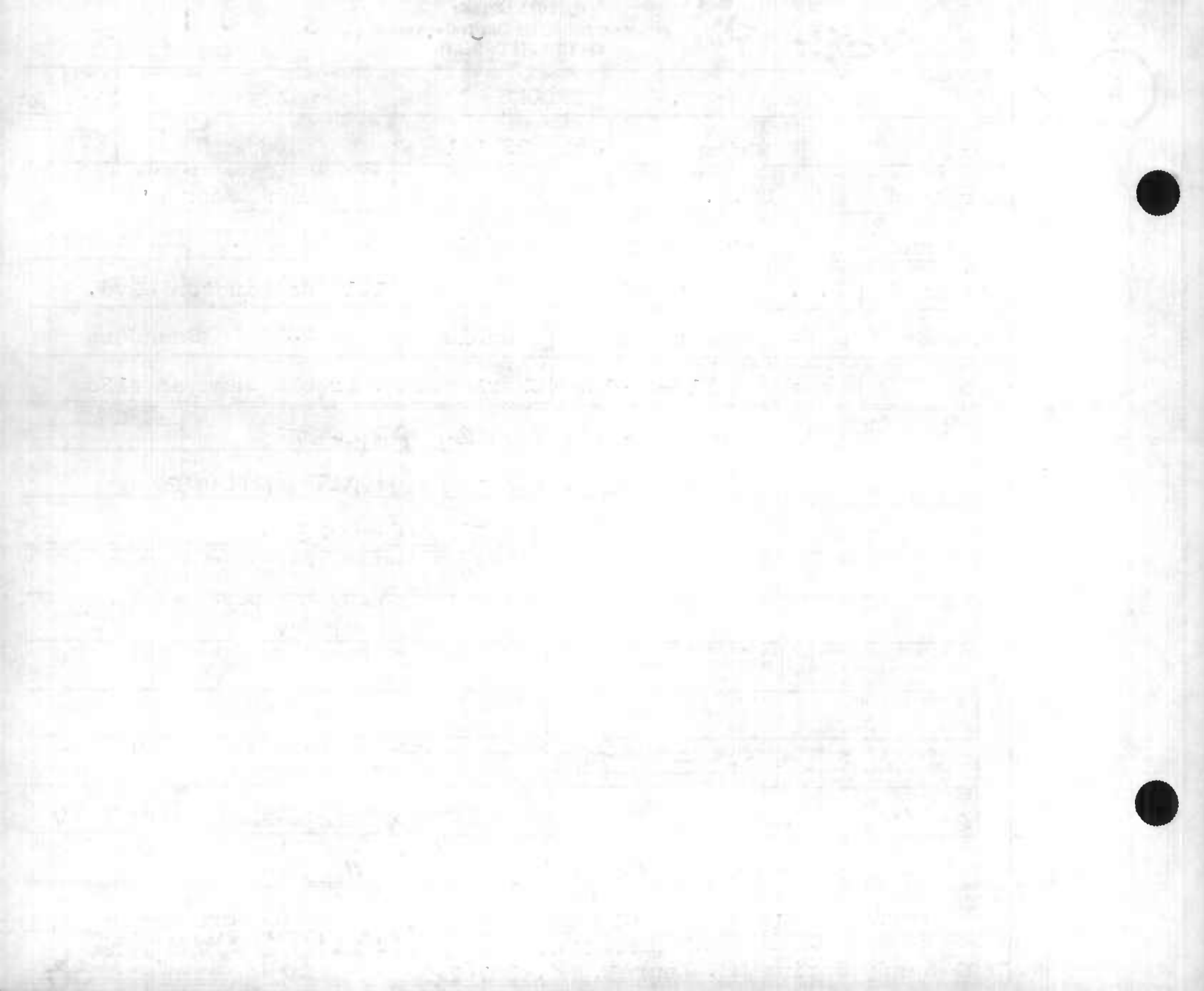
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST CLAUDE		MIDDLE R.	LAST BROOKS		2a. DATE OF DEATH MONTH DAY YEAR 10/03/84				2b. HOUR 11:40pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 23 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.						
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp						12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Self Emp.		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1210 Washington Blvd. 20707				
14. FATHER'S NAME FIRST MIDDLE LAST Claude - Brooks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rubie - Saunders										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Charlotte M. Brooks Same as #13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY HEART DISEASE.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I) (this hospital) attended the deceased from <u>2-26-19-84</u> to <u>10-3-19-84</u> , that (I) (we) lost saw the deceased alive on <u>2-26-19-84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22a. SIGNATURE <u>M. H. Chaudhry</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-4-84</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. H. CHAUDHRY</u>		22e. ADDRESS <u>Laurel Md. 20707</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/6/84		23c. NAME OF CEMETERY OR CREMATORY Old Trinity Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woolford Dorchester Md.						
24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME INC.		ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20707		25a. DATE REC'D. BY REGISTRAR OCT 9 1984		25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>						

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IMPORTANT: If item 21 is marked or checked, then any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				28302			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Fannie C. Brown				7a. DATE OF DEATH MONTH DAY YEAR 10 19 84			
3. SEX F				4. RACE Blabk		5. DATE OF BIRTH MONTH DAY YEAR 4 8 21 21	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 64 63	
10. CITY OR TOWN OF DEATH Clinton				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS / ZIP CODE			
13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Basil Gracey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Elizabeth Veaney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-16-5115		17. INFORMANT ADDRESS Augstine R. Brown 2310 Wyngate Road Suitland, MD 20746	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiopulmonary arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours
DUE TO, OR AS A CONSEQUENCE OF (b) leaking dissecting abdominal aneurysm							days
DUE TO, OR AS A CONSEQUENCE OF (c) ANARIC renal failure, post surgical							days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hepatitis							
19a. DATE OF OPERATION Oct. 15/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Grafting leaking abdominal aneurysm		20a. AUTOPSY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-5 , 19 84 , to 10-19 , 19 84 , that (I) (we) last saw the deceased alive on Oct. 19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter W. Yim M.D.				DEGREE M.D.		22c. DATE SIGNED Oct. 19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D.				22e. ADDRESS 1900 Old Branch Ave. Suite 101, Clinton, Maryland 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/24/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20018				25a. DATE REC'D. BY REGISTRAR OCT 23 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

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ROLLINS FUNERAL HOME, INC.
4330 HUNT PLACE, N.E.
WASHINGTON D.C. 20019

OCT 28 1964

CLERK - BIRMINGHAM 2042

PETER W. R. P.D.

J. H. W. R. P.D.

WIFE & CHILD ARE BOTH 101

10-28-64

10-28-64

at 10:30 P.M. on 10/28/64, I, J. H. W. R. P.D., being a duly qualified and licensed funeral director, do hereby certify that the above named deceased was born on 10/28/64 and died on 10/28/64.

Witness my hand and the seal of my office this 28th day of October, 1964.

J. H. W. R. P.D.

210-11-2112 (Washington, D.C.)

Joseph R. P.D. (Baltimore, Md.)

210-11-2112 (Baltimore, Md.)

210-11-2112 (Baltimore, Md.)

210-11-2112 (Baltimore, Md.)

210-11-2112 (Baltimore, Md.)

210-11-2112 (Baltimore, Md.)

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				2 8 3 0 3	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAWRENCE V. BROWN Jr.			2a. DATE OF DEATH MONTH DAY YEAR 10-07-84		2b. HOUR 12 45AM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR April 15, 1942	6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook	12b. KIND OF BUSINESS OR INDUSTRY Private	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 113 Elbee Drive 20640	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence V. Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy M. Smallwood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-38-5303	17. INFORMANT ADDRESS 113 Elbee Drive Dorothy M. Brown Indian Head, Maryland 20640		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALISED HERPES SIMPLEX</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACQUIRED IMMUNO-DEFICIENCY SYNDROME (AIDS)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> , 19 <u>84</u> , to <u>10-07</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10-06</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>N.B. Vellanki</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-9-1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.B. VELLANKI.		22e. ADDRESS PRINCE GEORGE'S GEN. Hospital, CHEVERLY MD. 20785.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-12-84	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Bapt.		23d. LOCATION CITY OR TOWN Marbury	COUNTY STATE Charles Md.
24. FUNERAL DIRECTOR NAME Thornton Funeral Home		ADDRESS Pomomkey, Md.		25a. DATE REC'D. BY REGISTRAR OCT 15 1984	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				28304			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FRANK E. BROWNELL				2a. DATE OF DEATH MONTH DAY YEAR 10 17 84			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 7 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PGG HOSPITAL AND MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY FURNITURE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS / ZIP CODE 7002 ANNAPOLIS RD. 20784			
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN LANDOVER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM (NA) BROWNELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARETB (NA) UNK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE STATES) 1922/26 577-05-3179		17 INFORMANT ADDRESS LUCY BROWNELL (SAME AS # 13)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infectious Process</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Organic Brain Syndrome</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19 <u>84</u> , to <u>Oct 16</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Oct 15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert J. Gereiger M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. GEREIGER M.D.				22e. ADDRESS 44074th Ave Hyattsville, MD 20784			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 19 OCT 84		23c. NAME OF CEMETERY OR CREMATORY MD. VETS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM P.G. MD.	
24. FUNERAL DIRECTOR HAL E. LANHAM F.H.				25a. DATE REC'D. BY REGISTRAR OCT 23 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 0 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONA B. Brownfield			2a. DATE OF DEATH MONTH DAY YEAR 10-22-84			7b. HOUR 4:45 P.M.					
3. SEX F female		4. RACE W hite		5. DATE OF BIRTH MONTH DAY YEAR 3-30-84		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PR: GEO. MD.					
10. CITY OR TOWN OF DEATH ADELPHI		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Adelphia Manor Care				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Milliner		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3602 Janet Road 20906		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 552-36-8477	
17. INFORMANT Niece				ADDRESS 8003 Piney Branch Rd Silver Spring, Md. 20910				17b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		17c. DATE SIGNED 10/22/84	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF (b) aortic Stenosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Min. 30 yr. 30 yr.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Anemia, senility.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 4-2-82, 19 to 10-22-84, 19, that the deceased saw the deceased alive on 10-22-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George B Patrick JMD						22c. DATE SIGNED 10/22/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B Patrick JMD						22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Oct. 22, 1984			23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR OCT 25 1984					
500 University Blvd., W. Silver Spring, Md.						REGISTRAR'S SIGNATURE Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALEX BUCKUS			2a. DATE OF DEATH MONTH DAY YEAR 10 26 84			2b. HOUR 7 JUA_M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 21 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY P.G.		13c. CITY OR TOWN Lanham Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6910 Varnum (20784)	
14. FATHER'S NAME FIRST MIDDLE LAST George (W) Buckus			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (W) Zawacki							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII			16b. SOCIAL SECURITY NO. 162-16-1399		17. INFORMANT ADDRESS Mary Buckus (Same as #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Brain Anoxia & Malnutrition DUE TO, OR AS A CONSEQUENCE OF: (c) hepatic encephalopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Seizure disorder, Diabetic mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 84 , to 10/26 , 19 84 , that (I) (we) last saw the deceased alive on 10/25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.										
22b. SIGNATURE Leroy E. Cohen DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leroy E. Cohen						22e. ADDRESS 6201 Guilford St. L.H.				
23a. BURIAL, CREMATION, REMOVAL Cremation			23b. DATE 27 Oct 84		23c. NAME OF CEMETERY OR CREMATORY Lee Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.			
24. FUNERAL DIRECTOR NAME Hales Lanham ADDRESS F.H. 903 Annapolis Rd						25a. DATE REC'D. BY REGISTRAR 31		25b. REGISTRAR'S SIGNATURE John William Rindell		

MEDICAL CERTIFICATION

DATE: 10/10/2010 TIME: 10:10 AM

8

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR, FBI
SUBJECT: [Illegible]
DATE: 10/10/2010
TO: [Illegible]
FROM: [Illegible]

[Extremely faint, illegible body text of the memorandum, appearing to be several paragraphs of a report.]

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					2 8 3 0 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Enrique F. Burton					2a. DATE OF DEATH MONTH DAY YEAR 10 19 84 2b. HOUR 4:45AM					
3 SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sep. 15, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Bookbinder-U.S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Luther Burton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS 8719-Pickadilly Taylor Burton- Pl., Springfield, Va.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible Perforated ulcer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old Peptic Ulcer disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>① Severe Dehydration (on admission) ② Adeno Carcinoma Prostate</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>10-11-</u> 19 <u>84</u> to <u>10-19-</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10-18-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Rexalty Murthy</u>		DEGREE <u>M.B.B.S.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>10-20-84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>REVATHY MURTHY</u>				22e. ADDRESS <u>G130, Landover Rd, Landover MD</u>						
23a. BURIAL, CREMATION, REMOVAL (CHECK) <u>Cremation</u>		23b. DATE <u>10/22/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cre.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood Pr. Geo. Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Nalley's F.H. Inc.</u>		ADDRESS <u>Mt. Rainier Md.</u>		DATE REC'D. BY REGISTRAR <u>OCT 29 1984</u>		25b. REGISTRAR'S SIGNATURE <u>J. A. Davidson-Pondell</u>				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					2 8 3 0 8		
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR P	
Katherine NMI BUSH			October 8, 1984			11:40 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	11 01 15	68 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA		Prince George's County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	Doctor's Hosp of PG County		Home maker		—		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN			YES <input type="checkbox"/> NO <input type="checkbox"/>		20716 3909 New Haven Court #4		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME				
No known family unknown			unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT				
NO		347-14-9651	Friend Pat Diamond 15809 Pinecroft Lane, Bowie, Md. phone 249-9534				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 1a) Cerebro-vascular Accident							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last							
1b) Cerebral Vascular Disease.							
DUE TO, OR AS A CONSEQUENCE OF							
1c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
Perforated Ulcer, Cholecystitis, Congestive Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
7/3/84		Perforated Ulcer, Cholecystitis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/3/84, 19, to 10/8/84, 19, that (I) (we) last saw the deceased alive on 10/8/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE				22c. DATE SIGNED	
Stuart Turkow		MD					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Stuart Turkow, MD		7200 Greenway Cat. Dr. #430 Greenbelt, Md. 20770					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		10/9/84					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Anatomy Board				OCT 11 1984		Julia Davidson-Randall	
ADDRESS				BALTO., Md.			

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Three people (only)

Homeless

3000 in the city

3000 in the city

in the city

in the city

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in the city

in the city

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 0 9
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE OF DEATH		2d. HOUR	
JOYCE		10-2 19 84		1:28 P M	
3. SEX		4. RACE		5. DATE OF BIRTH	
female		White		June 29, 1923 61 YRS.	
6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
61 YRS.		MONTHS DAYS HOURS MIN.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
England		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Clinton		Southern Maryland Hospital Center		Homemaker	
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN	
Maryland		Prince Georges		Clinton	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Robert		Christiana		213-44-5226	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(son)		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
1845 Dove Ct.		DUE TO, OR AS A CONSEQUENCE OF			
Severn, MD 21144		(b) DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
CHRONIC OBSTRUCTIVE PULMONAY DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Augusto P. Rodriguez		M.D. Deputy		10-2-84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial				Riverview Cemetery	
23d. LOCATION		23e. REGISTRAR'S SIGNATURE			
Strasburg, Virginia		Jana Davidson-Randall			
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D BY REGISTRAR	
Capitol Funeral Service, Falls Church, VA				OCT 8 1984	

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 2 8 3 1 0			
1. DECEASED NAME (TYPE OR PRINT) VIRGINIA M. BURCH				2a. DATE OF DEATH MONTH DAY YEAR 10 - 20 - 84				2b. HOUR 12:45AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 8, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY FOOD SERVICE			
13a. STATE MD.		13b. COUNTY P.G.C.		13c. CITY OR TOWN RIVERDALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4512 MADISON ST. 20737			
14. FATHER'S NAME FIRST MIDDLE LAST JACOB PINKUS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAE UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-05-4561		17. INFORMANT MIKE BARNES		ADDRESS SAME AS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disseminated Coagulopathy DUE TO, OR AS A CONSEQUENCE OF (c) Acute Leukemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized Seizures, metabolic problems											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 10/16/84 , 19 84 , to 10/19 , 19 84 , that (1) (we) last saw the deceased alive on 10/19 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert Ruderman				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/20/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Ruderman MD				22e. ADDRESS 6510 KENILWORTH AVE, Riverdale Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10-20-1984		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.C. MD.					
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. ADDRESS RIVERDALE, Md. 20737				25a. DATE REC'D BY REGISTRAR 24 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 1 1

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anne Virginia BURNS			2a. DATE OF DEATH MONTH DAY YEAR October 6, 1984		2b. HOUR 4:30am M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 12, 1934	6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of P.G. County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator	12b. KIND OF BUSINESS OR INDUSTRY US Government	
13a. STATE Maryland			13b. COUNTY Pr. George's	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank C. Disney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva M. Nicholson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - - -	17. INFORMANT ADDRESS 12703 Craft Lane Elizabeth D. Stephenson Bowie, MD 20715		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RIGHT HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERE COPD</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>84</u> , to <u>10/6</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/5</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R.L. Carrem m			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/7/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. CARREM m			22e. ADDRESS 711 E. CAPITOL ST SE DC 20003		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE October 8, 1984	23c. NAME OF CEMETERY OR CREMATORY Trinity Episcopal Ch. Cem., Upper Marlboro, Pr. George's		23d. LOCATION CITY OR TOWN COUNTY STATE MD	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Rd. Bowie, MD 20715		25a. DATE REC'D. BY REGISTRAR OCT 9 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

BP

6

Female	Orchestra	February 16, 1934	50
Washington, DC	USA		
Mr. George's Bowls			
Mr. George's Bowls			
Frank	C. Henry		
12,03 Crest Lane			
Elizabeth D. Stephenson			
12,03 Crest Lane			
12,03 Crest Lane			

12,03 Crest Lane
Elizabeth D. Stephenson
12,03 Crest Lane
12,03 Crest Lane

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 1 2
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR		
VICTOR			J.			CARLINO			Sr. M			OCT 27 1984 7 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH DAY YEAR			2d. HOUR				
Male	White	Mar. 12, 1934	50 YRS.	MONTHS	DAYS	OCT 27 1984	OCT 27 1984			7 PM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Louisiana		U.S.A.				Prince George Co. MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR Vocation				
Laurel		Greater Laurel Beltsville Hosp				Program Manager				Westinghouse				
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
Maryland				P.G. Co.		Laurel		13e. STREET ADDRESS						
								12802 North Point La. 20708						
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST						FIRST MIDDLE LAST								
Samuel						Carrie								
						Mauro								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
Yes				1956-1978		437-48-4637 Katherine E. Carlino same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:														
(b) _____														
DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
				P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION						
								CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED		
Richard L. Whelton				M.D. Deputy										
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
RICHARD L. WHELTON				7100 Baltimore College Park Rd										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
Burial				10/31/84		Roselawn Mem. Park				Baton Rouge, Louisiana				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
FLECK FUNERAL HOME, INC.						OCT 30 1984				dia Davidson-Randall				
7601 Sandy Spring Rd, Laurel, Md. 20707														

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wayne E. CARROLL			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10-20 1984			2b. HOUR M 134		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3-25-59	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 25	IF UNDER 1 YR. MONTHS DAYS 10-20 1984	IF UNDER 24 HRS. HOURS MIN. 10-20 1984	7c. DATE PRONOUNCED MONTH DAY YEAR 10-20 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Prince Georges		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Capitol Hgts	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4805 Addison Road			
14. FATHER'S NAME FIRST MIDDLE LAST Richard S. Carroll			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Brown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 212-80-8528			17. INFORMANT Richard Carroll			ADDRESS 4805 Addison Rd. md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy			DATE SIGNED 10-20-84		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 26, 1984		23c. NAME OF CEMETERY OR CREMATORY Church of God House of Prayer		23d. LOCATION (CITY OR TOWN) COUNTY STATE Brandywine md.	
24. FUNERAL DIRECTOR NAME Comer-Hodges F.H.			ADDRESS 4901 Marlboro Pike, Coral Hills, md.			25a. DATE REC'D. BY REGISTRAR OCT 25 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

12-2-21
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12-2-21
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR																																																																			
Arthur			Carter Jr.			10-30-84			10-30-84			11:50																																																																			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR																																																																	
Male		Black		5 24 34		50 YRS.		MONTHS DAYS		HOURS MIN.		10-30-84		11:50																																																																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																																																																			
N.C.				USA								Prince George's County MD.																																																																			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																																																															
Beltsville				11344 Cherry Hill Rd. Apt. 203																																																																											
13a. STATE																13b. COUNTY																13c. CITY OR TOWN																13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																13e. STREET ADDRESS															
D.C.																																Washington																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																1437 Ervin St. N.W. 99999 20009															
14. FATHER'S NAME																15. MOTHER'S MAIDEN NAME																16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)																16b. SOCIAL SECURITY NO.																17. INFORMANT ADDRESS															
Arthur																Mary																																																Karen Ford 1336 I St., N.W.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																															
PART I DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a) Gunshot wound of head and chest																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																																																															
19a. DATE OF OPERATION																19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 10:50 PM 10-29-84																21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot during altercation																																															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>																21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM ETC.) apartment																21f. LOCATION CITY OR TOWN STREET COUNTY STATE 11344 Cherry Hill Rd. Apt. 203 Beltsville, Md																																															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																																															
ACTUAL SIGNATURE Margarita A. Korell																TITLE (SPECIFY) Assistant																DATE SIGNED 10-30-84																																															
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.																ADDRESS 111 Penn Street																																																															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial																23b. DATE 11/3/84																23c. NAME OF CEMETERY OR CREMATORY Church Cemetery																23d. LOCATION CITY OR TOWN COUNTY STATE Enfield N. C.																															
24. FUNERAL DIRECTOR NAME Wm. C. March F/H																ADDRESS 1101 E. North Ave.																25a. DATE REC'D. BY REGISTRAR NOV 1 1984																25b. REGISTRAR'S SIGNATURE John Davidson-Randall																															



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HELEN LOFTUS CHOW			2a. DATE OF DEATH Month OCT Day 29 Year 84		2b. HOUR 7:00 A.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 19 NOV 37		6. AGE (In years last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) BROOKLYN NY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.	
10. CITY OR TOWN OF DEATH ADELPHI		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8309 Curry Place		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MA		13b. COUNTY PG	13c. CITY OR TOWN ADELPHI	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8309 CURRY PL
14. FATHER'S NAME First Middle Last THOMAS BRENDON LOFTUS		15. MOTHER'S MAIDEN NAME First Middle Last MARY ELLEN CIRCLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 094-30-135		17. INFORMANT Address Howard Chow (Husband) Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA LIVER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BREAST DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 14 Feb 84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BREAST TUMOR		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1 June, 1981 , to 29 OCT , 19 84 , that (I) (we) last saw the deceased alive on 21 OCT 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas Fogarty		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 29 OCT 84	
22d. PHYSICIAN'S NAME (Type) Thomas Fogarty, MD		22e. ADDRESS 7676 New Hamp. Ave. Langley Park, Md			
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE 11/1/84	23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City or Town) (County) (State) Adelphi PG Maryland	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S.M.D.		ADDRESS		25a. REC'D BY REGISTRAR OCT 29 1984	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

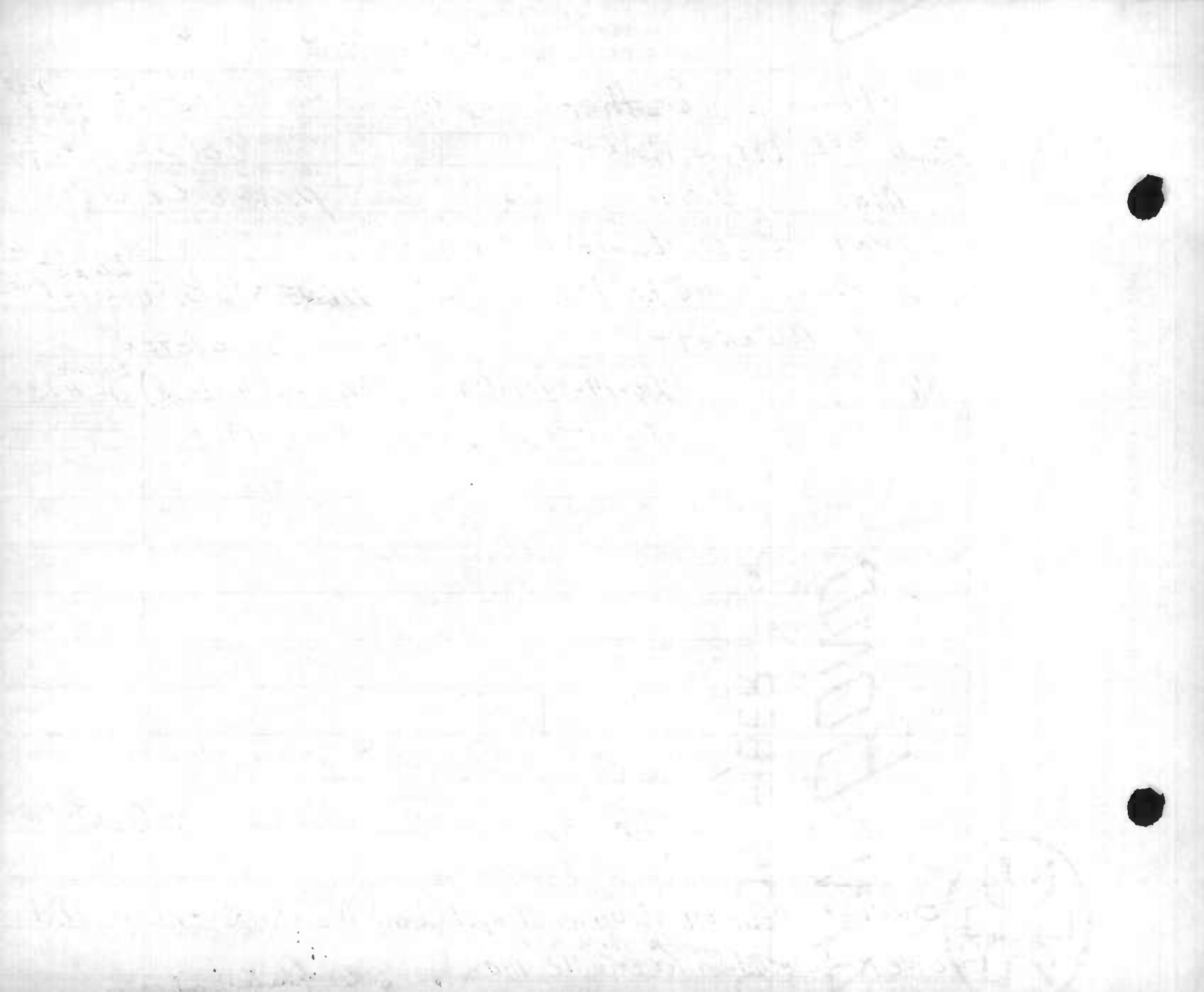
DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Mamie Esther Chapman</i>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>Oct. 30, 1984</i>		2b. HOUR OF DEATH HOUR MIN <i>8:48 PM</i>	
3. SEX <i>Female</i>	4. RACE <i>Blk</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 13, 1920</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>64</i> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's Md.</i>	
10. CITY OR TOWN OF DEATH <i>Laurel</i>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greater Laurel Beltsville Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't</i>	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE COUNTY <i>Md Prince George's</i>		13b. CITY OR TOWN <i>Beltsville</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>C. GARRETT</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mamie Singleton</i>		16. ADDRESS <i>Same</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>216-14-3481</i>		17. INFORMANT <i>Casper Chapman (Husband)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Inf.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>					
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John P. Jones</i>		TITLE (SPECIFY) M.D. <i>Dep.</i>		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED <i>Oct 30, 1984</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>11-3-84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Queens Chapel Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Muir Kirk Pr. Geo. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>		ADDRESS <i>246 N. Wash. St. Rockville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>Nov 3, 1984</i>	
				25b. REGISTRAR'S SIGNATURE <i>John P. Jones</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 8 3 1 7
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) GEORGE T CHARLESWORTH		2a. DATE OF DEATH MONTH DAY YEAR 10 30 84	
3 SEX MALE		4 RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR Nov 29, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10 CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) MALCOM CROW USAFMC, ANDREWS AFB, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Military officer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE V		13b. COUNTY Washington DC	
13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2400 Good Hope Rd., S.E. #104			
14. FATHER'S NAME FIRST MIDDLE LAST John Charlesworth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Cullen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1931-1963 579-52-8737	
17 INFORMANT Audrey S. Charlesworth		ADDRESS Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac and pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>end stage ischemic cardiomyopathy & renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12 Oct 84</u> 19 <u>84</u> to <u>30 Oct 84</u> 19 <u>84</u> that (I) (we) lost saw the deceased alive on <u>30 Oct 84</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE X Hilary K. Ellwood		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) X Hilary K. Ellwood		22c. DATE SIGNED 30 Oct 84	
22e. ADDRESS MALCOM CROW USAFMC ANDREWS AFB, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5 Nov 1984	
23c. NAME OF CEMETERY OR CREMATORY Shepherd Park Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Hendersonville N.C.	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 10/30/84	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28318

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEMUEL S CHILOS			2a. DATE OF DEATH MONTH DAY YEAR 10-23-84		2b. HOUR 3.40 P.M.
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR JAN 25, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY P H Co.	
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Clinton	13d. STREET ADDRESS / ZIP CODE 8201 Belfont Lane Clinton Md 20735	
14. FATHER'S NAME FIRST MIDDLE LAST Charles			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Washington		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 230 01 3630		17. INFORMANT ADDRESS Clinton, Md. James Buckner-nephew-8201 Belfont Ln	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) acute renal failure DUE TO, OR AS A CONSEQUENCE OF (c) cardiac respiratory arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-21 , 19 84 , to 10-23 , 19 84 , that (I) (we) last saw the deceased alive on 10-23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Cirio A. Montanez MD		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CIRIO A. MONTANEZ MD		22e. ADDRESS 5308 Dodge PK Rd Landover MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/29/84	23c. NAME OF CEMETERY OR CREMATORY Harmony	23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG Maryland		
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE			25a. DATE REC'D. BY REGISTRAR 10/29/84		
ADDRESS 2617 Pa Ave. S.E. Wash DC			25b. REGISTRAR'S SIGNATURE John K. ...		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



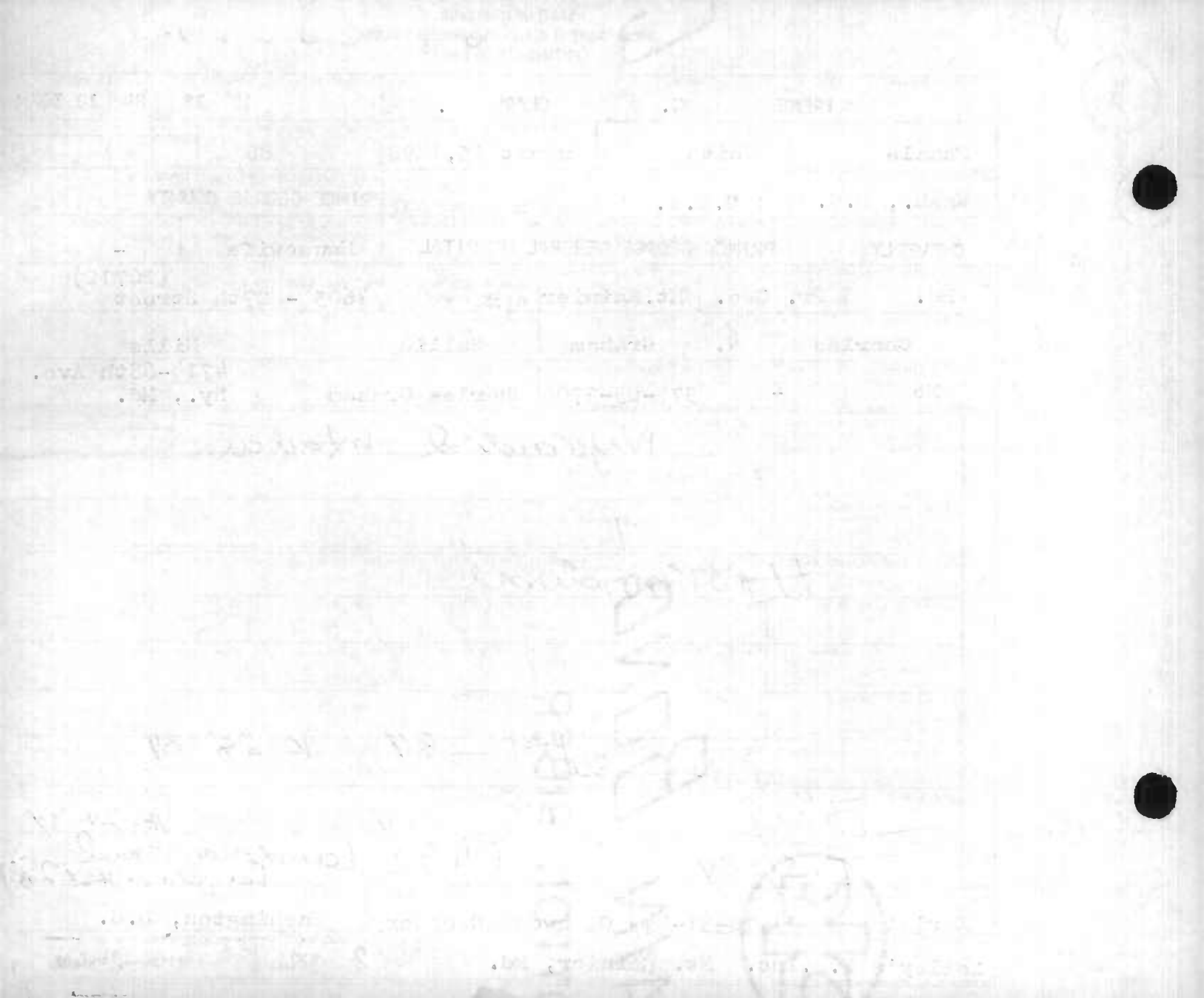
BP _____
DHMM - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				2 8 3 1 9			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) IRENE G. CLARK				2a. DATE OF DEATH MONTH DAY YEAR 10 28 84 2b. HOUR 10 30 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 15, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS / ZIP CODE (20712) 4605 - 27th Street			
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Graham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Mills			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. - 577-05-3708		17. INFORMANT Charles Graham		ADDRESS 4714-68th Ave. Hy., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>10-12-84</u> to <u>10-28-84</u> , that (I) (we) last saw the deceased alive on <u>10-12-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>T. SURY</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-29-84	
22d. PHYSICIAN'S NAME (Last, First, Middle) T. SURY				22e. ADDRESS 6492 Landover Road Landover, Md 20785			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-31-84		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.				25a. DATE REC'D. BY REGISTRAR NOV 2 1984		25b. REGISTRAR'S SIGNATURE Felia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					2 8 3 2 0	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR
FIRST MIDDLE LAST			MONTH DAY YEAR			P
Charles Bryant COLLINS, Sr.			October 31, 1984			11:05 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR
Male	White	MONTH DAY YEAR Dec. 21, 1915		68 YRS.		IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Georgia		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Marshall & Naval Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Fitzgerald Collins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Kirbo			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
Yes-Navy Retired		579-50-8691		Mrs. Minnie M. Collins Address Same as No# 13c.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>probable seizure directly</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>a cardiac arrhythmia</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Obstructive Pul. Disease, 5/yr. may be</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28/84</u> , 19 <u>10/31/84</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>10/31/84</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Glenn R. Tension</u>		DEGREE <u>M.D.</u>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/1/84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Glenn R. Tension</u>		22e. ADDRESS <u>Melwood Bankhouse Office #18 9450 Penn. Ave. Upper Marlboro</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 5, 1984		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer Arlington Va.
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25. DATE REC'D BY REGISTRAR 26. REGISTRAR'S SIGNATURE <u>John R. ...</u>		

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7. Coach's Zone (H. J. Gattavillo)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

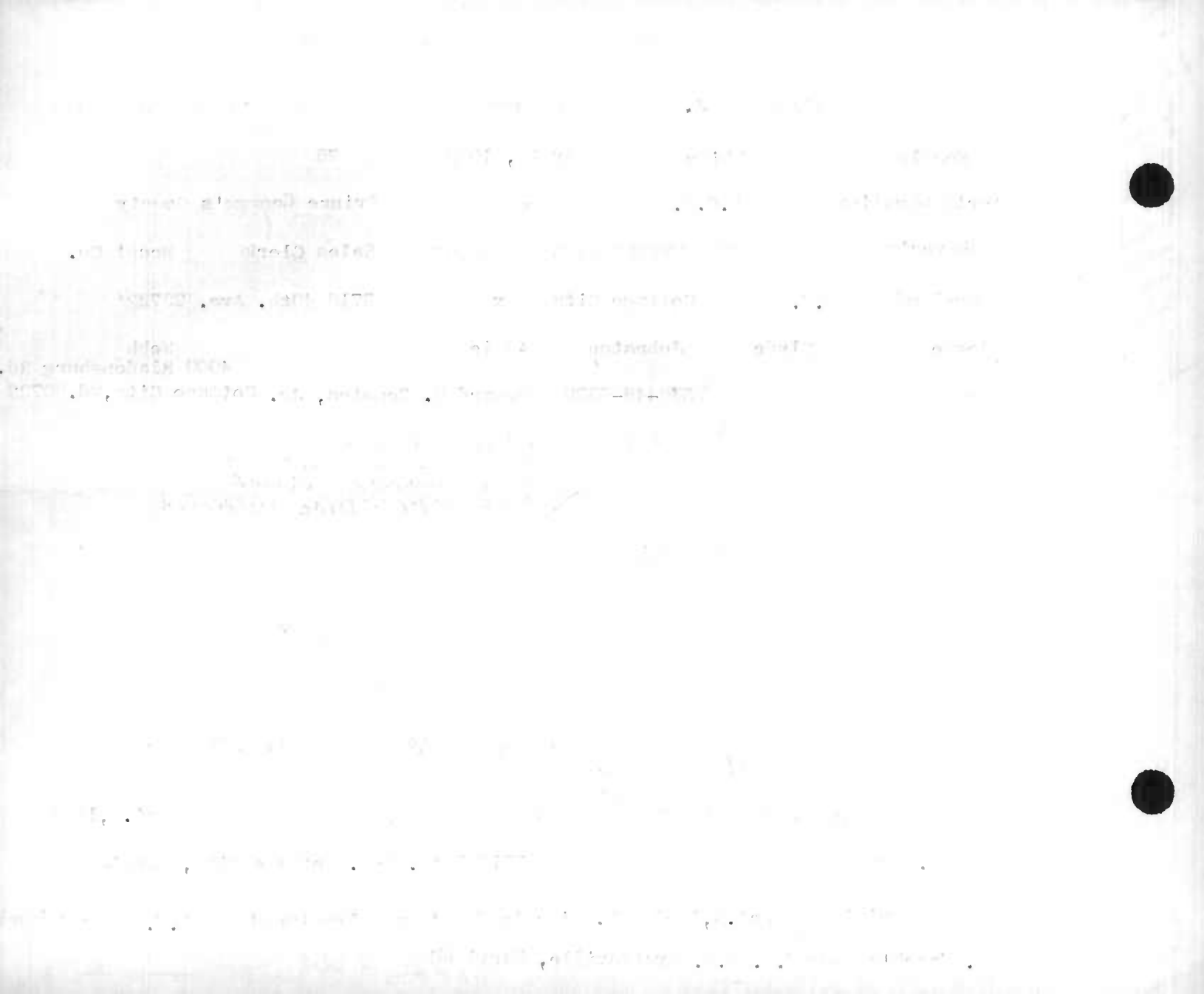
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				2 8 3 2 1			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) SELMA J. COMPTON				2a. DATE OF DEATH MONTH 10 DAY 03 YEAR 84		2b. HOUR 4 36A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 14 YEAR 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S CENTRAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Cottage City		13e. STREET ADDRESS / ZIP CODE 3718 40th. Ave., 20722	
14. FATHER'S NAME FIRST Jesse MIDDLE Clyde LAST Johnston				15. MOTHER'S MAIDEN NAME FIRST Addie MIDDLE Webb LAST Webb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-48-5379		17. INFORMANT ADDRESS 4000 Bladensburg Rd. Howard H. Compton, Jr. Cottage City, Md. 20722			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR FIBRILLATION ACUTE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 4 1978 to AUG 27 1984 , that (I) (we) last saw the deceased alive on 10-3 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. S. Nayar				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Oct. 3, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Nayar				22e. ADDRESS 3717 38th. Ave. Cottage City, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood COUNTY P.G. STATE Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 5 1984 25b. REGISTRAR'S SIGNATURE John Davidson-Bandera			

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ROBIN		B.	CONDE		9 25 19 84					M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	Filipino	Dec 11, 08		75 YRS.					10 2 19 84 6p M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Philippines		USA					Prince George's County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Suitland		2422 Porter Ave.			Barber		self Employ			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a. STATE				PG		YES <input type="checkbox"/> NO <input type="checkbox"/>		2422 Porter Avenue 20746		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
Robin				Conde						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		WWII		564-18-6321		Robin M. Conde		8712 Brae Brook Dr Lanham, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>										
(c) <u></u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
		P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION						
				STREET		CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED				
<u>Ann M. Dixon</u>		M.D. Assistant MEDICAL EXAMINER				10-3-84				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								
Ann M. Dixon, M.D.		111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE		
Cremation		10-4-84		Cedar Hill Crematory		Suitland		PG Md		
24. FUNERAL DIRECTOR NAME		25a. DATE RECD. BY REGISTRAR								
Robert E. Wilhelm		Oct 10 1984								
Funeral Home		Suitland, Md.								

A

RECEIVED

(12)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 50M 4/B3
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					2 8 3 2 3	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			
FIRST MIDDLE LAST			MONTH DAY YEAR			
Esther Elizabeth CONROY			October 5, 1984			
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian	March 8, 1922		62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		U.S.A.			Prince Georges County, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Lanham		Drs. Hospital of P.G. Co.		Housewife		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland		P.G.	College Pk.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	9743 51st Place 20740	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Estel Farlow			Lilly Sue Brantton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS			
No		N?A?	226-28-1696 James Conroy Same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>CONSTRUCTIVE PERICARDITIS</u>					Several years	
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					2 days	
(b) <u>PNEUMONIA</u>						
DUE TO, OR AS A CONSEQUENCE OF						
(c) <u>SEPTICAEMIA</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/5/84</u> to <u>10/5/84</u> , that (I) (we) last saw the deceased alive on <u>10/5/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE			22c. DATE SIGNED	
		MD				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
Azher Hussain M.D.		4917 Edgewood Rd., College Park, Md. 20740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		10/7/84	Balt. Wash. Crem.		Laurel P.G. Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FLECK FUNERAL HOME INC. 7601 Sandy Spring Rd. Laurel Md.			OCT 9 1984			

1

2

UNITED STATES
DEPARTMENT OF THE ARMY
WASHINGTON, D. C.

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF THE ARMY
SUBJECT: [Illegible]

[Illegible text block]

172017
CNO
MAY 1964
[Circular stamp with a star]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3. THIS PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

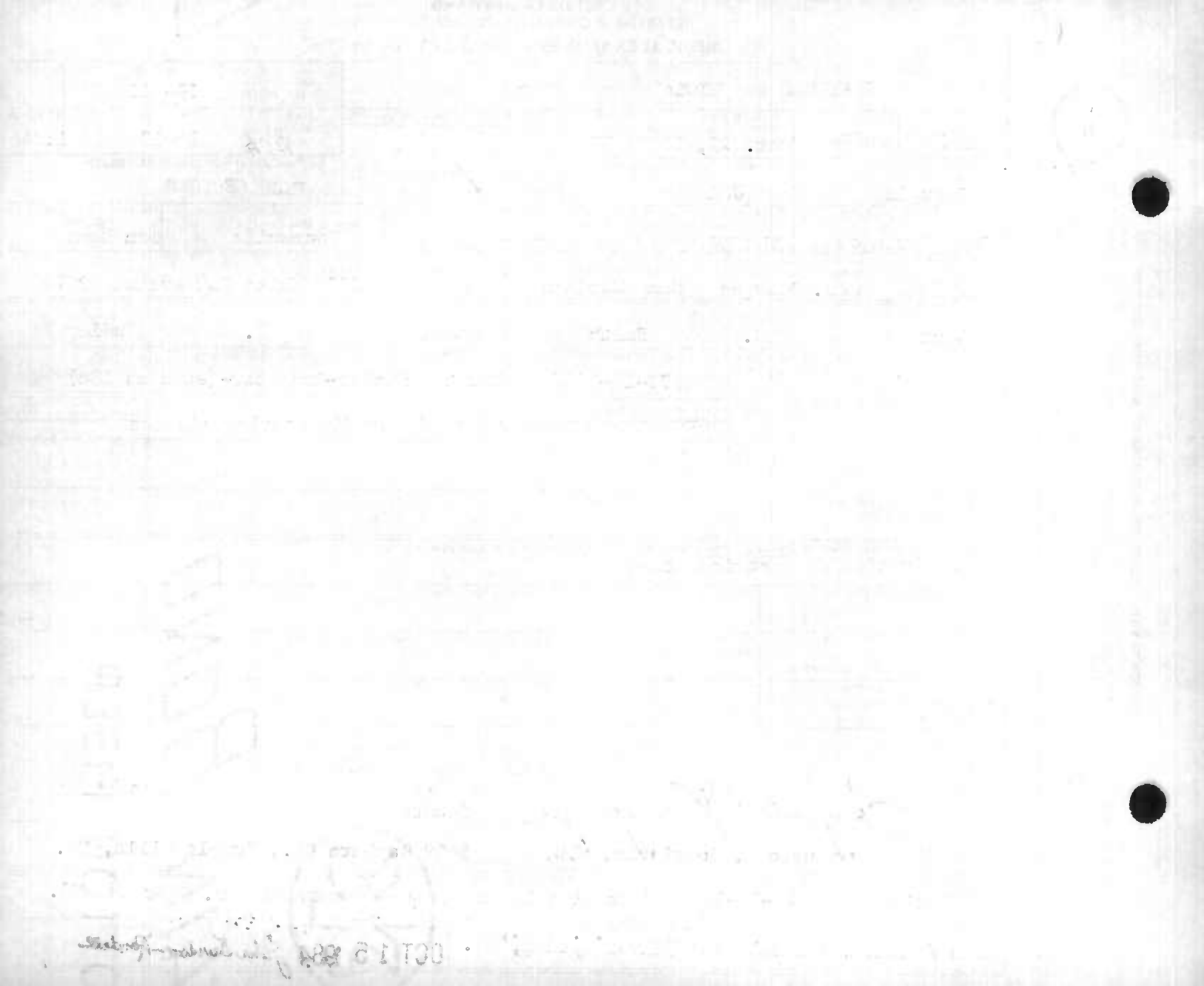
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST GERTRUDE		MIDDLE VIOLA		LAST COOKE		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 10-13-84				2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD 10-13-84		2d. HOUR 1:34A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD			
10. CITY OR TOWN OF DEATH Camp Springs				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY own home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Pr. Georges		13c. CITY OR TOWN Camp Springs		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6500 White Oak Avenue 20748					
14. FATHER'S NAME FIRST MIDDLE LAST Albert M. Smith						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan E. Dudley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A				(IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. 579-14-6666		17. INFORMANT ADDRESS Dorothy Keefer-daughter-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypertensive arteriosclerotic cardiovascular disease</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a: <u>aspiration of gastric contents</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 10-13-84			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-16-1984		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION Brentwood Pr. Georges Md.					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				ADDRESS 11800 N.H. Ave., Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 8 3 2 5
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT E. CRAMPTON			2a. DATE OF DEATH MONTH DAY YEAR 10 27 84			2b. HOUR 7:30 p.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORG'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Building Contractor	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert I. Crampton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Mae Mundy				13e. STREET ADDRESS / ZIP CODE 3002 Xavier Lane 20747	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 578-48-2723		17. INFORMANT ADDRESS Leroy Crampton Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) old pneumonia @ Lung + new pneumonia @ Lower Lung DUE TO, OR AS A CONSEQUENCE OF (c) ASHD - atrial arrhythmia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASHD - atrial arrhythmia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-27 , 19 76 , to 10-27 , 19 84 , that (I) (we) lost saw the deceased alive on 10-27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE William Kent Furst					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kent Furst, M.D.					22e. ADDRESS 11701 Livingston Rd. Ft. Washington Md 20744				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 31 Oct 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm					25a. DATE REC'D. BY REGISTRAR NOV 07 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		
ADDRESS Suitland, Md.									

BP

Name		Address		Occupation		Date	
John Doe		123 Main St		Teacher		1940	
Jane Smith		456 Elm St		Homemaker		1940	
Robert Johnson		789 Oak St		Engineer		1940	
Mary White		101 Pine St		Nurse		1940	
James Brown		202 Cedar St		Farmer		1940	
Elizabeth Green		303 Birch St		Retailer		1940	
William Black		404 Spruce St		Scientist		1940	
Margaret Gray		505 Willow St		Artist		1940	
Charles King		606 Ash St		Lawyer		1940	
Dorothy Lee		707 Hickory St		Musician		1940	
Frank Miller		808 Sycamore St		Writer		1940	
Helen Wilson		909 Magnolia St		Dancer		1940	
George Taylor		1010 Poplar St		Historian		1940	
Betty Adams		1111 Chestnut St		Actress		1940	
Edward Baker		1212 Walnut St		Politician		1940	
Frances Clark		1313 Elm St		Journalist		1940	
Harold Evans		1414 Oak St		Architect		1940	
Irene Foster		1515 Pine St		Translator		1940	
Jack Gibson		1616 Cedar St		Inventor		1940	
Katherine Hall		1717 Birch St		Explorer		1940	
Leo Harris		1818 Spruce St		Philosopher		1940	
Mildred Jones		1919 Willow St		Economist		1940	
Norman King		2020 Ash St		Astronomer		1940	
Olivia Lee		2121 Hickory St		Botanist		1940	
Philip Miller		2222 Sycamore St		Zoologist		1940	
Rebecca Wilson		2323 Magnolia St		Geologist		1940	
Samuel Taylor		2424 Poplar St		Physicist		1940	
Teresa Adams		2525 Chestnut St		Chemist		1940	
Victor Baker		2626 Walnut St		Biologist		1940	
Wendy Clark		2727 Elm St		Anthropologist		1940	
Xavier Evans		2828 Oak St		Linguist		1940	
Yvonne Foster		2929 Pine St		Historian		1940	
Zachary Gibson		3030 Cedar St		Archaeologist		1940	

Continued on next page

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

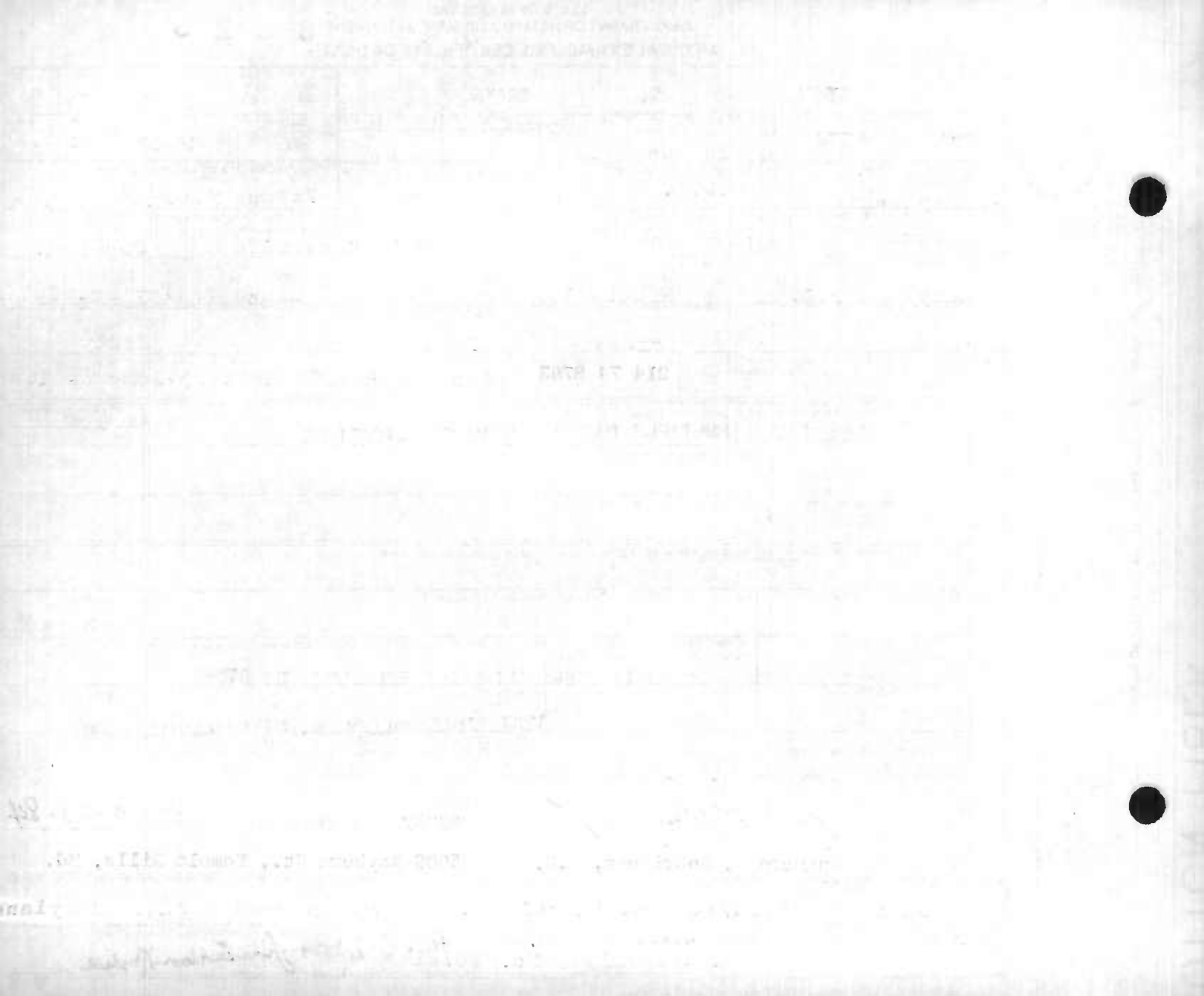
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ETHEL S. CRAYS			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 10-27 19 84			2b. HOUR A M 9:50 A		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 10 04	6. AGE (IN YEARS) (LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-27 19 84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Probst			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Beaty			13e. STREET ADDRESS 1207 Kings Valley Dr. 20716		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 214 74 8793		17. INFORMANT ADDRESS Sara Withers (Daughter) Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8804 MULTIPLE INJURIES WITH COMPLICATIONS IMMEDIATE CAUSE (a) 8804 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-13 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) SLIPPED & FELL DOWN THE STEPS			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1207 KINGS VALLEY DR., MITCHELLVILLE, MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) Deputy			DATE SIGNED 10-28-84		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/30/84		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood		23d. LOCATION CITY OR TOWN COUNTY STATE P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons 4739 Baltimore Avenue Funeral Home P.A. Hyattsville, Md. 20781								
25. DATE REC'D. BY REGISTRAR NOV 0 2 1984						25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/B2
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL Kenneth CRIST			2a. DATE OF DEATH MONTH DAY YEAR Oct. 23 84			2b. HOUR 12:10 AM			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 6 15 05		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Barber	
13a. STATE Maryland			13b. COUNTY Pr. George		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Hileman Crist			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bella Unknown			13e. STREET ADDRESS 7100 Southlawn Dr. 20745			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 178-28-9216		17. INFORMANT ADDRESS Altoona, Pa. Replogle Funeral Home 2636 W. Chestnut Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia - Ventricular DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular D								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 wks Yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Parkinson									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from March 16, 19 84 , to Oct 23, 19 84 , that (I) last lost saw the deceased alive on Oct 22, 19 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) last death (did not) view the body after death.									
22b. SIGNATURE Thomas D. Fieldson MD						DEGREE MD		22c. DATE SIGNED 10/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. Fieldson, M.D.						22e. ADDRESS BRANDYwine, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/84		23c. NAME OF CEMETERY OR CREMATORY Alto Reste Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Altoona Pa.			
24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.						25a. DATE REC'D. BY REGISTRAR OCT 25 1984		25b. REGISTRAR'S SIGNATURE G. P. Kalas	

A



Male
Female

Cauc.
Neg.

6 15 02 78
x

Barber

Unlisted

7100 Southern Ln. 20712

x

Oxon Hill

Ex. George

Maryland

Unknown

Unlisted

Crist

Hilman

176-24-2216
Biologic Research Home 2037 W. Chestnut Ave.
Altoona, Pa.

no

10/26/54
also Roste Cemetery
Altoona

O.P. Rains 6100 Oxon Hill Rd. Oxon Hill, Md.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Casper B. Curry			2a. DATE OF DEATH MONTH DAY YEAR October 20, 1984			2b. HOUR 2:05p. M			
3 SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR December 15, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp of Prince Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Car Inspector		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Curry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH Abraham			13e. STREET ADDRESS / ZIP CODE 6700 Belcrest Road # 503 (20782			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 716-12-9296		17. INFORMANT ADDRESS Anna M. Curry Wife Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASTROCYTOMA OF BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>HYPERTENSION.</u>									
19a. DATE OF OPERATION 9.4.84.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASTROCYTOMA OF BRAIN				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8.29.84</u> to <u>10.20.84</u> , that (I) (we) last saw the deceased alive on <u>10.20.84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE V.P. Singh				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10.21.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.P. SINGH				22e. ADDRESS 5632 Annapolis Rd Blairstown Md 20710					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland			
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR OCT 25 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATION NO. 17

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 8 3 2 9
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Curry			2a. DATE OF DEATH MONTH DAY YEAR October 16, 1984			2b. HOUR 9:25P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 17, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY drug store		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Jessup		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8295 Washington Blvd 20794	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Keeney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Bossom							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 218 01 0009		17. INFORMANT ADDRESS Rudy Gray same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Myocardopathy - DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from October 1983 to October 16, 1984 , that (I) (we) lost saw the deceased alive on October 16, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William A Warren MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A Warren			22e. ADDRESS 321 Prince George St Laurel 20707							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 19, 1984		23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Savage, Maryland			
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 25 1984				
						25b. REGISTRAR'S SIGNATURE Lelia Davidson				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



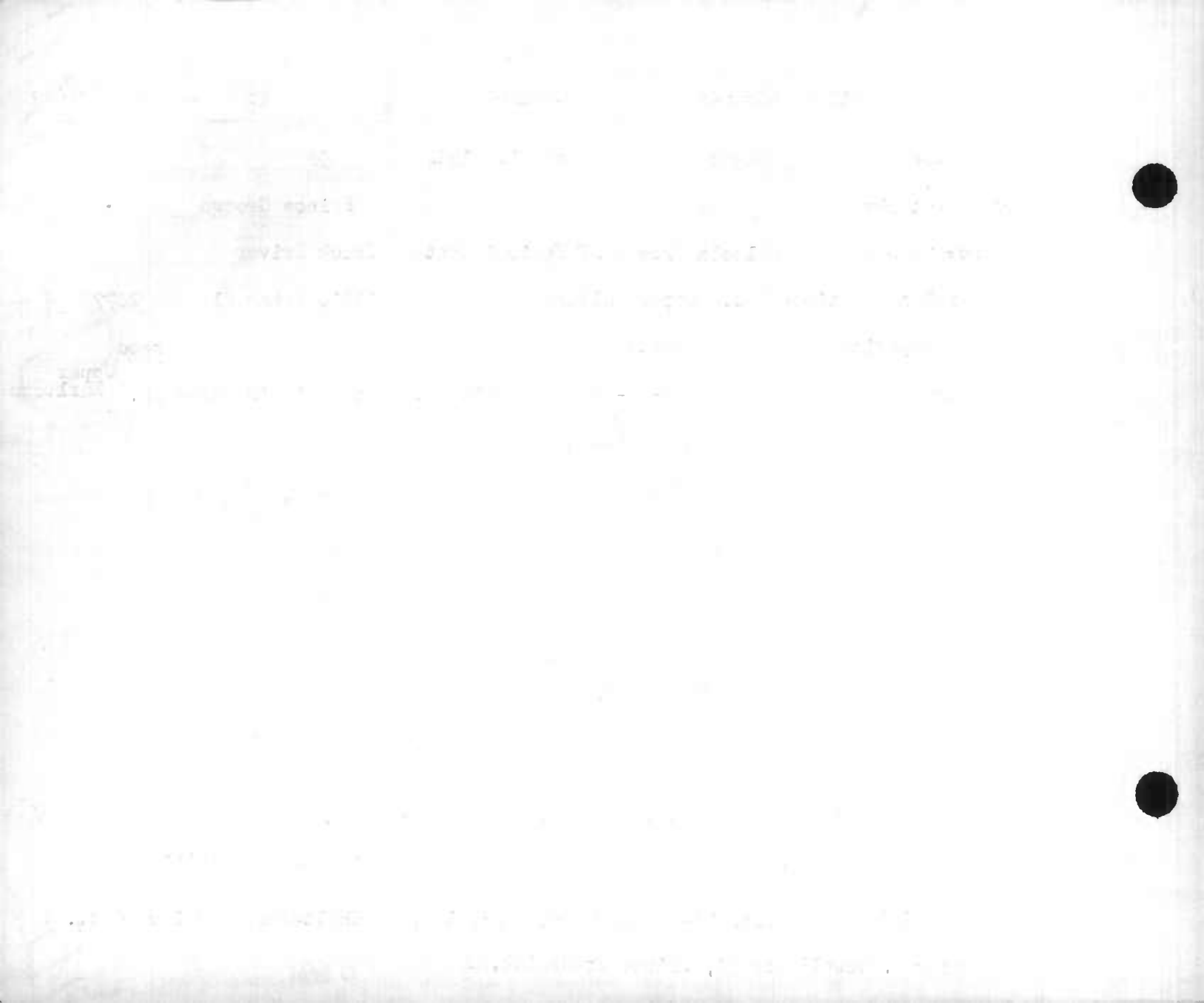
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2 8 3 3 0					
1. FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST OLLIE		MIDDLE LINCOLN		LAST CUSTARD		2a. DATE OF DEATH MONTH OCT		DAY 10		YEAR 84		2b. HOUR 12:45p M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH June		DAY 10		YEAR 1932		6. AGE (IN YEARS (LAST BIRTHDAY)) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.									
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF Medical Center								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Upper Malboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17010 Usher Pl. 20772							
14. FATHER'S NAME FIRST Prosperity				MIDDLE Custard		15. MOTHER'S MAIDEN NAME FIRST Mary				MIDDLE Sneed		LAST Sneed			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 405-32-9695		17. INFORMANT ADDRESS Vernice V. Custard 17010 Usher PL. Upper Marlboro									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma of Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from <u>30 Sept</u> , 19 <u>84</u> , to <u>10 Oct</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10 Oct</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22a. SIGNATURE <u>Martin A. DeFrancesco MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22b. DATE SIGNED <u>10 Oct 84</u>							
22c. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN A DEFRANCESCO				22d. ADDRESS MALCOLM GROW USAF MEDICAL CENTER											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 17-84		23c. NAME OF CEMETERY OR CREMATORY Cheltenham MVC Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince Geo., Md					
24. FUNERAL DIRECTOR NAME Spencer E. Sewell Box 31, Prince Frederick, Md				25a. DATE REC'D. BY REGISTRAR OCT 16 1984				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Wendell</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be certified by law)

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jack Daniels, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 10 28 84			2b. HOUR 11 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 28 84		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 6	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland				13b. CITY OR TOWN Hyattsville		13c. STREET ADDRESS / ZIP CODE 6608 Stockton Lane 20784	
14. FATHER'S NAME FIRST MIDDLE LAST Jack Daniels, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Gertrude Meadows			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Jack Daniels, Sr. (Father) Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congenital Abnormalities DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congenital Abnormality of GI System - Gastroesophagus							
19a. DATE OF OPERATION 10/28/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastroesophagus		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from October 19 84 , to October 19 84 , that (I) (we) last saw the deceased alive on October 28 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Larry Thos Jones				DEGREE MD		22c. DATE SIGNED 10/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Larry Thos Jones				22e. ADDRESS Prince George's General Hospital Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood P.G. Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons 4739 Baltimore Ave Funeral Home P.A. Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR 10/31/84			
				25b. REGISTRAR'S SIGNATURE John Davidson Rodell			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 3 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET T. DAVIDONIS			2a. DATE OF DEATH MONTH DAY YEAR 10 14 84			2b. HOUR 10:50AM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 23 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.				
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince George		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1514 Redford Drive 20744	
14. FATHER'S NAME FIRST MIDDLE LAST George Verbilla			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Saukitis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No			16b. SOCIAL SECURITY NO. 202-26-1609		17. INFORMANT Anna Semyan		ADDRESS 1514 Redford Dr. Ft. Washington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE URINARY INFECTION & RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) SENILITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1) CONGESTIVE HEART FAILURE ADVANCED 2) HYPOVOLEMIC SHOCK										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 12 19 84 to Oct. 14 19 84 , that (I) (we) last saw the deceased alive on Oct. 13 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE B. Hakki Adam, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. HAKKI ADAM, M.D.					22e. ADDRESS 6172 OXON HILL RD. #101, OXON HILL, MD 20745					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/17/84		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Centralia Penna.			
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Charles W. Moore					25. DATE REC'D. BY REGISTRAR OCT. 17 1984		25b. REGISTRAR'S SIGNATURE G. Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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George H. Kaiser, General Home
1100 Ocean Hill, Maryland
Crown Hill, Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 AND 6 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		UNK.#84-84		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		8 4 2 8 3 3 3		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Edward Dean						7a. DATE KNOWN OF DEATH ESTIMATED XX 10-29 19 84		7b. HOUR 5:05					
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR 4-23-1911		6 AGE (IN YEARS) LAST BIRTHDAY 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 10-29 19 84		2d. HOUR 5:05	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10 CITY OR TOWN OF DEATH Capitol Hqts.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6100 blk. Central Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY FED. GOV'T.			
13a. STATE D.C.				13b. COUNTY NONE		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 816 E. ST. N.E. #310 20002			
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 227-12-4237		17 INFORMANT ADDRESS JOHN EDWARD DEAN (SAME AS ITEM #13)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a). Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR est. 2:30 PM 10-29 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6100 blk. Central Ave., Capitol Hqts., Prince George's Co., Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												George's Co., Md.	
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 10-29-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 11-1-1984		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. 517						ADDRESS 11th ST. S.E. WASH.				25a. DATE REC'D. BY REGISTRAR NOV. 5 1984		25b. REGISTRAR'S SIGNATURE <i>Lila Davidson-Randall</i>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 3 4
REG. NO.

1- FOR
STATE
REGISTRAR

Hazel (NMN) Dean

1. DECEASED NAME

FIRST

MIDDLE

LAST

Hazel Dean

2a. DATE OF DEATH

MONTH

DAY

YEAR

10-23-84

2b. HOUR

MIN.

9:15 P M

3. SEX

Female

4. RACE

Caucasion

5. DATE OF BIRTH

MONTH

DAY

YEAR

3-29-1924

6. AGE (IN YEARS LAST BIRTHDAY)

60

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Tennessee

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges County, MD

10. CITY OR TOWN OF DEATH

New Carrollton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

8609-Powhatan Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

retired

12b. KIND OF BUSINESS OR INDUSTRY

Housewife

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

VA

13b. COUNTY

Alexandria

13c. CITY OR TOWN

Alexandria

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

37-East Linden Street (22301)

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Clellie

-

Siler

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Eliza

-

Powers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

212-20-7018

17. INFORMANT

(Daughter)

Willasue Spreen New Carrollton, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b)

CARCINOMA of THE LUNG, SQUAM CELL

DUE TO, OR AS A CONSEQUENCE OF

(c)

METASTATIC CARCINOMATOSIS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 72, to 10-23 19 84, that (I) (we) lost saw the deceased alive on 10-23-19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Prospero Zavallos

DEGREE

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c. DATE SIGNED

04/25/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

PROSPERO ZEVALLOS MD

22e. ADDRESS

Prospero Zavallos M.D.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

10-27-1984

23c. NAME OF CEMETERY OR CREMATORY

Lee's Crematory

23d. LOCATION

Wash., DC

8450 Landon Road

Nevery, Md. 20785

24. FUNERAL DIRECTOR

J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002

25a. DATE REC'D. BY REGISTRAR

31 1984

25b. REGISTRAR'S SIGNATURE

Juli Davidson

Israel (1948) - 1948

Household

866 - 0000 0000

(1948) - 1948

Household

(1948) - 1948

866 - 0000 0000

866 - 0000 0000

866 - 0000 0000

866 - 0000 0000

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866 - 0000 0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IRVING L. DEAN			2a. DATE OF DEATH MONTH DAY YEAR 10 27 84			2b. HOUR 12:12p m	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 14, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engineer	
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Caleb Dean		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella M. Joy		13e. STREET ADDRESS / ZIP CODE 6106 Manor Road (20735)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Matilda C. Dean Same As #13 A-E			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident at renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18/84</u> , 19 <u>84</u> , to <u>10/26</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John C. Patterson</u>				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Patterson				22e. ADDRESS 1501 Surratt Road, Suite 302, Clinton, Md 20735			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 31, 1984		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR Lee Funeral Home, Inc. Old Alexander Ferry Road, Clinton, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 30 1984		25b. REGISTRAR'S SIGNATURE <u>Carleton R. Randall</u>	



Handwritten text, possibly a signature or date, appearing as "1900" and "1901".

Handwritten "X" mark.

Handwritten "1900" and "1901" marks.

Handwritten text, possibly "1900" and "1901".

Handwritten text, possibly "1900" and "1901".

Handwritten "1900" and "1901" marks.

Handwritten text, possibly "1900" and "1901".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST SADIE			MIDDLE Marie			LAST DEAN			2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 10		DAY 14		YEAR 84		2b. HOUR 9:35			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 8 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH 10		DAY 14		YEAR 84		2d. HOUR 9:35					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.											
10. CITY OR TOWN OF DEATH Clinton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY N/A									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE Virginia						13b. COUNTY Augusta		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rte. 3, Box 110					
14. FATHER'S NAME FIRST MIDDLE LAST Edward DeMar						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Moore						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						16b. SOCIAL SECURITY NO. 224-68-5340		17. INFORMANT James E. Dean, Jr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 10/15/1984											
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/17/84				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland											
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				ADDRESS Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR OCT 17 1984				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>											

IN 10 10 10 10
IN 10 10 10 10
IN 10 10 10 10

Marie

Feb. 8 1907 77

Washington, D.C. U.S.A. x Prince George's

W.A. 22950 x spousewife

Virginia Augusta Wynessboro x Wm. J. Box 110

Edward John Martha Moore

No 221-68-510 James H. Lane, Jr. 7001 Prince George's
Rd. Washington, D.C.

10/17/84 Cedar Hill Cemetery

George A. Kates General Home Oxon Hill, Md.
10/17/84 Cedar Hill Cemetery
Outland P.O. Maryland

Medical Examiner Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			2 8 3 3 7 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Esther Tudor DEAVERS						October 30, 1984			1:40p. M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE	CAUCASIAN	APRIL 10, 1906		78 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WASHINGTON, D.C.	U.S.A.			Prince George's County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	Doctors' Hospital of Prince Geo. Co.			HOUSEWIFE					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MARYLAND PRI. GEORGES GLENDALE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11023 BROOKLAND ROAD 20769				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
AUGUST H. BECKER, SR.			MARY			GOETZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO			577-24-1793		WILLIAM H. DEAVERS SAME AS 13. HUSBAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amoebic ulcer during Surgery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADENOCARCINOMA of Rectum with</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastasis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks -</u> <u>2 yr -</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Chronic sclerotic heart disease and Embolic vascular disease</u>									
19a. DATE OF OPERATION <u>10-30-84</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cancer of Rectum</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10-30-84</u> to <u>10-30-84</u> that (I) (we) last saw the deceased alive on <u>10-30-84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George S. Banning MD</u>			22c. ADDRESS <u>5806 E. Ave Hyattsville Md 20904</u>			22d. DATE SIGNED <u>10-30-84</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			11/2/84		FT. LINCOLN CEMETERY		BRENTWOOD PRI GEO MD.		
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>		
					NOV 5 1984				

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[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1600.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				2 8 3 3 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anita Comfort deLeon				2a. DATE OF DEATH MONTH DAY YEAR 10-22-84		2b. HOUR 7:30 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 4, 1902		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philippines		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD	
10. CITY OR TOWN OF DEATH Mt. Rainier		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4530 32nd Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Library of Congress	
13a. STATE Maryland				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier	
14. FATHER'S NAME FIRST MIDDLE LAST James Hall Comfort				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celerina Topacio		16. ADDRESS 2603 Arcola Avenue Wheaton, Md. 20902	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				17b. SOCIAL SECURITY NO. 214-30-0465		17. INFORMANT son Leo de Leon	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dissecting Aortic Aneurysm</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 32 min		12 hrs	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK				21b. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>10/12/84</u> to <u>10/22/84</u> that (1) <u>(last)</u> saw the deceased alive on <u>10/12/84</u> and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above.				22b. SIGNATURE <u>Edward J. Pacious</u>		22c. DATE SIGNED 10/23/84	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Edward J. Pacious, M. D.				22b. ADDRESS 1712 Eye Street, N.W. Washington, D.C.		22c. DATE SIGNED 10/23/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.				24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR OCT 25 1984	
25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>				25c. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25d. DATE REC'D. BY REGISTRAR OCT 25 1984	

1. ΑΙΣΙΟΔΟΜΕΙ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 3 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DELIA B. DEVINE			2a. DATE OF DEATH MONTH DAY YEAR 10 22 84			2b. HOUR 9:15 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 12, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Retail Ind.			
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 7904 Prince Georges Drive 20744			
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Barnes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida V. Donaldson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. -- 577-26-2281		17. INFORMANT ADDRESS Katherine V. Dean Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE STROKES DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CANCER COLON, INFECTED DECUBUS ULCERS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/23 19 84 to 10/22 19 84, that (I) saw the deceased alive on 10/21 19 84 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.											
22b. SIGNATURE P. Wisotsky M.D.					DEGREE M.D.		22c. DATE SIGNED 10/22/84		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) P. Wisotsky M.D.					22f. ADDRESS 6188 OXON HILL RD., OXON HILL, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-25-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md				
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home					25a. DATE REC'D. BY REGISTRAR OCT 30 1984					25b. REGISTRAR'S SIGNATURE John F. [Signature]	

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1. 23-2-78

2. 23-2-78

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3. 23-2-78

4. 23-2-78

5. 23-2-78

6. 23-2-78

7. 23-2-78

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

8 3 4 0
REG. NO.

1- FOR STATE REGISTRAR		2a DATE KNOWN OF DEATH		MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		Michael Alan Dial		10 27 1984		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD	
Male	Cauc.	9-5-1967	17 YRS.			10 27 1984 12:18	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Missouri		USA				Prince George's County, MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Clinton		Southern Maryland Hospital		Student		High School	
13a STATE		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13d STREET ADDRESS	
Maryland		Charles Hughesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 269-D, 20637	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		17 INFORMANT (FATHER) ADDRESS	
Michael Reece Dial		Sharon Lois Ely		No		Michael R. Dial, Same as line 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY:							
8151 IMMEDIATE CAUSE (a) Internal injuries							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		11:01 P.M. 10 26 1984		Passenger in auto/fixed object impact			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION			
		street		19906 Aquasco Rd, Aquasco, P.G CO., MD.			
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Thomas D. Smith		M.D. Deputy Chief		10/27/84			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial		10-30-84		Immanuel Methodist Cem.		Baden, P.G., Maryland	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE DEATH ANNOUNCED			
Huntt Funeral Home		Waldorf, Maryland		OCT 30 1984			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

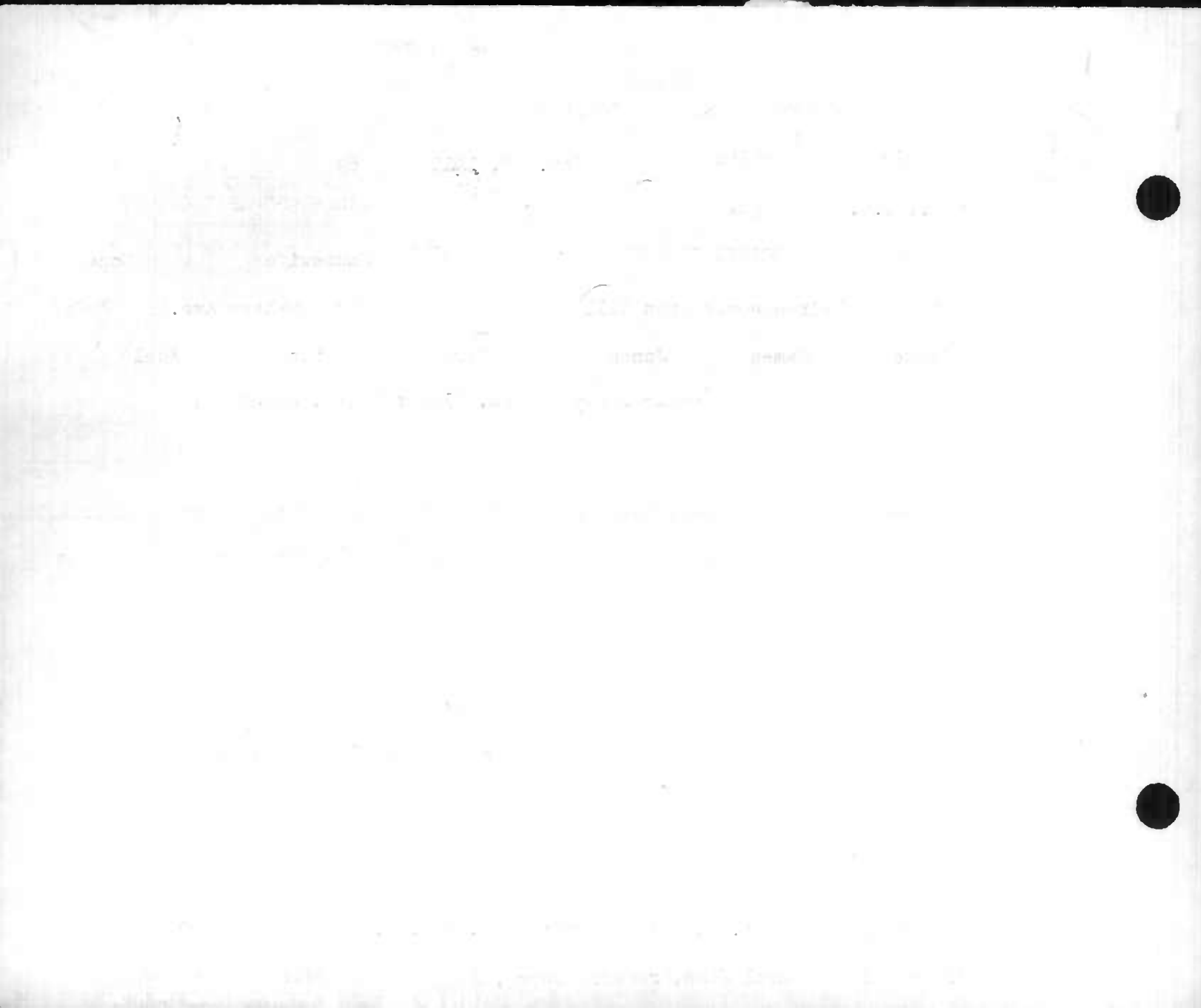
2 8 3 4 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELINOR S. DICKERSON			2a. DATE OF DEATH MONTH DAY YEAR 09-29-84			2b. HOUR 12 :05AM M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 13, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Prince George		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1313 Southern Ave. SE 20032		
14. FATHER'S NAME FIRST MIDDLE LAST Jesse James Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Etta Abel								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578-36-5233		17. INFORMANT ADDRESS Mrs. Elinor Snead, Beaverdam, VA						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GF bleeding, Esoph. Varices, Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u> <u>Pneumonia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>84</u> , to <u>9/29</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9/29</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Joseph Richichi, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>9/29/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph Richichi, M.D.</u>					22e. ADDRESS <u>PGGH + MC</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Unit. Meth. Ch.		23d. LOCATION CITY OR TOWN COUNTY STATE Stafford, VA				
24. FUNERAL DIRECTOR <u>Wilson Smith</u> Wilson Smith Funeral Home, Fredericksburg, VA					25a. DATE REC'D. BY REGISTRAR OCT 9 - 1984					25b. REGISTRAR'S SIGNATURE <u>Johanna Davidson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 4 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harvey John Dickerson			2a. DATE OF DEATH MONTH DAY YEAR October 25, 1984		2b. HOUR 7:55AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 15, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Molder	12b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory	
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 20707 231 Red Clay Road Apt-#201	
14. FATHER'S NAME FIRST MIDDLE LAST Costley M. Dickerson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose E. Salmon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-42-2976		17. INFORMANT ADDRESS Mrs. Frances C. Dickerson No# 13e.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

VENTRICULAR ARRHYTHMIA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

PULMONARY EMBOLISM, RENAL INSUFFICIENCY, CHRONIC OBSTRUCTIVE PULM. DISEASE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 1982 to Oct 1984 , that (I) (we) last saw the deceased alive on 10-25-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		22c. DATE SIGNED 10/25	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESMALHADO		22e. ADDRESS 321 PRINCE GEORGE ST			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 29, 1984	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
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24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland	25. DATE REG'D. BY REGISTRAR Oct 29 1984	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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Released by *D. Rodriguez*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPT. OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 4 3

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Harold Woodrow Dickinson, Sr.			2a DATE OF DEATH MONTH DAY YEAR 10 09 84		2b HOUR 5:59 PM
3 SEX Male	4 RACE Cau.	5 DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1914	6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES		
10 CITY OR TOWN OF DEATH CLINTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't
13a STATE Maryland		13b COUNTY Charles	13c CITY OR TOWN Waldorf	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Urbank Dickinson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Green			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-07-4557		17 INFORMANT ADDRESS Margaret W. Dickinson same as 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) terminal Carcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Obstructive Lung Disease					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) <input checked="" type="checkbox"/> personally attended the deceased from 10/9 19 84 to 10/9 19 84 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 10/9 19 84 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death.					
22b SIGNATURE L. Kaufman		DEGREE M.D.		22c. DATE SIGNED 10/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. KAUFMAN		22e. ADDRESS 10903 FT. WASH. RD., Ft. WASH. Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-12-84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Colmar Manor, P.G., Md.		23e. DATE REC'D. BY REGISTRAR OCT 11 1984		23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24 FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Md.		25a. DATE REC'D. BY REGISTRAR OCT 11 1984			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. 8 3 4 4		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles S. Doane Jr.				2a. DATE OF DEATH MONTH DAY YEAR 10 8 84		2b. HOUR 9:55A M			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 1 20 16		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician		12b. KIND OF BUSINESS OR INDUSTRY US Air Force	
13a. STATE Maryland				13b. COUNTY Pr. George		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles S. Doane, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Ballou					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Catherine R. Doane same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (This hospital) attended the deceased from 9-25 19 84 to 10-8 19 84 , that (I) met last saw the deceased alive on 10-8 19 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I never ^{did not} view the body after death.)									
22b. SIGNATURE Eleanor S. Stewart, MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-8-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eleanor S. Stewart, MD.				22e. ADDRESS Group Health Assn.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/11/84		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR OCT 11 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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107-01-116 Collection of letters from 1947-1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

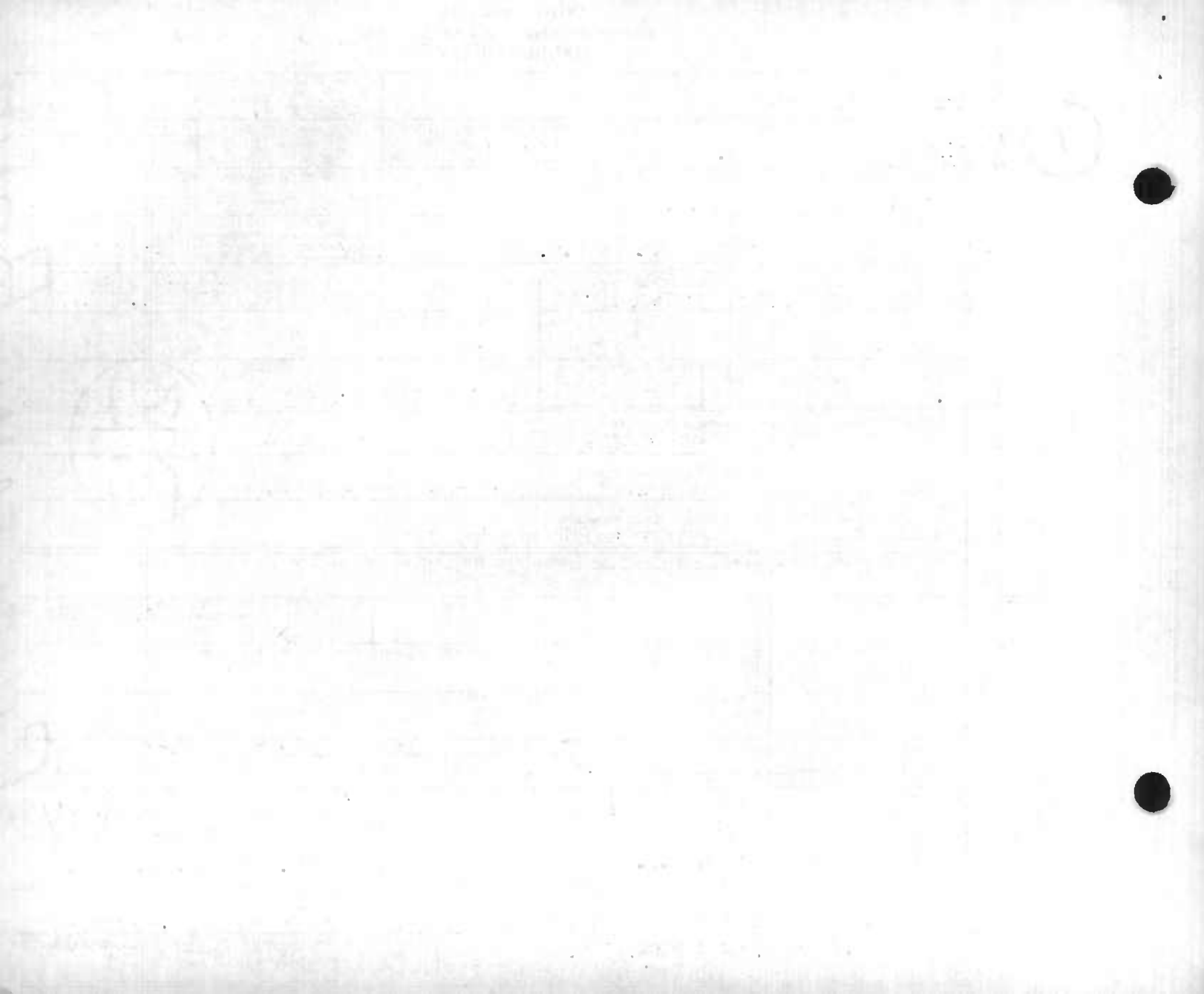
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 4 5

1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
I. DECEASED NAME FIRST MIDDLE LAST Joseph J. Doris		October 4, 1984		6:40am	
3. SEX Male	4. RACE Caus.	5. DATE OF BIRTH MONTH DAY YEAR 11/18/07	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges COUNTY MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hosp. of P.G.Ct		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired SALESMAN 12b. KIND OF BUSINESS OR INDUSTRY CANDY & TOBACCO		
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN OWINGS MILLS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS XXXXX (21117) 5 GREEN MOUNTAIN CT., APT. 5A	
14. FATHER'S NAME FIRST MIDDLE LAST ISADORE DORIS	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA NOLL		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 213-09-5865		17. INFORMANT ADDRESS ALLAN DORIS 14908 NOTLEY RD. SILVER SPRING, MD 20904			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic hypernephroma, stage D</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myelophthesic anemia, CAD</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> , 19 <u>83</u> , to <u>10/4</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Lewis Hilliard Dennis</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Hilliard Dennis, M.D.		22e. ADDRESS 831 University Blvd. Silver Spring, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10-5-84	23c. NAME OF CEMETERY OR CREMATORY TIFERETH ISRAEL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ROSDALE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		25a. DATE REC'D. BY REGISTRAR OCT 11 1984			
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						2 8 3 4 6	
1 - FOR STATE REGISTRAR						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nathaniel (nmn) DOWNEY					2a. DATE OF DEATH MONTH DAY YEAR October 7, 1984		2b. HOUR 5:15P M
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Assistant	
13a. STATE Maryland		13b. COUNTY Greenbelt		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Square Downey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Young			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 406 16 1720A		17. INFORMANT ADDRESS 6204 Springhill Drive Mrs. Aurelia Downey-wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Essential hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/30/1984</u> to <u>10/7/1984</u> , that (I) (we) last saw the deceased alive on <u>10/7/1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Hussain</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/9/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AZHER HUSSAIN				22e. ADDRESS 4917 Edgewood Road College Park MD			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE Oct. 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Louisville Cemetery		23d. LOCATION CITY OR TOWN Louisville, Kentucky	
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Road,				25. DATE REC'D. BY REGISTRAR OCT 11 1984			

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NO. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. That permit remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 2 8 3 4 7			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 10 3 84			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANGELINE AGNES DROGOZ				2b. HOUR 1:21 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLNOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN OXON HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 575 WILSON BRIDGE DR. 20745		14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH LYPP		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES LYPP			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 843-03-2654		17. INFORMANT ADDRESS LAWRENCE DROGOZ SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). e PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Lung Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9/82</u> , 19 <u>84</u> , to <u>10/3</u> , 19 <u>84</u> , that (I) (we) lost <u>the deceased</u> on <u>10/3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE		22c. DATE SIGNED <u>10/4/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. JOSEF R.D.</u>				22e. ADDRESS <u>7501 Surpath Rd. CLINTON, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-9-84		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM		23d. LOCATION CITY OR TOWN COUNTY STATE CHICAGO COOK ILLNOIS	
24. FUNERAL DIRECTOR NAME ADDRESS AREHART FUNERAL HOME, INC. LA PLATA, MD.				25a. DATE REC'D. BY REGISTRAR <u>OCT 8 1984</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP



U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
JUL 15 1964
MEMORANDUM
TO : DIRECTOR
FROM : SAC, CHICAGO
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows]

[Illegible text follows]

CHICAGO, ILLINOIS
JUL 15 1964
[Illegible text follows]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 4 8	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Darlene Mae DuBeau							2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9-19-84		2b. HOUR PM 11:30		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 31 56		6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.		IF UNDER 1 YR. MONTHS DAYS 0 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-19-84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County		
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Porter			12b. KIND OF BUSINESS Queenstown Apts.	
13a. STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3258 Queenstown Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Defibaugh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deloris Ballinge								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-66-1214			17. INFORMANT ADDRESS Lawrence DuBeau, Husband, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosed Aneurysm of Left Coronary Artery DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 10-16-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street - Baltimore, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-24-1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		
24. FUNERAL DIRECTOR NAME Francis Gaschs Sons, P.A.						ADDRESS H Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR OCT 16 1984		25b. REGISTRAR'S SIGNATURE <i>Mona Anderson-Randell</i>	



NAME OF PERSON

September 20, 1947

Living Record Number

Address

City and State

County

Married, name of wife

Occupation

Education

Religion

Political Party

Other

Remarks

Signature

Date

Place

Official

Signature

Date

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 28349	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>DUBOSE IRENE</u> <u>DUBOSE</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10</u> <u>10</u> <u>84</u>		2b. HOUR <u>355A</u> M
3. SEX <u>F</u>	4. RACE <u>B</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>9</u> <u>2</u> <u>19</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>65</u> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (COUNTRY) <u>S.C.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Prince George</u> MD.	
10. CITY OR TOWN OF DEATH <u>Takoma Park Md</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON ADVENTIST Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY <u>Maryland</u> <u>Montgomery</u> <u>Silver Spring</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>10921 Innwood Avenue</u> <u>20902</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Ivery Weldon</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Amanda McCray</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>170 12 7903</u>		17. INFORMANT ADDRESS <u>Harrisburg Pa</u> <u>Inwood House 7102 Silver Spring MD</u> <u>Tawnya R. DuBose-Johnson-daughter</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive M I with severe CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic renal failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>10/3/84</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/9/84</u> 19 <u>84</u> to <u>10/10/84</u> 19 <u>84</u> that (I) (we) saw the deceased alive on <u>10/9/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Smith H.O., M.D.</u>		DEGREE		22c. DATE SIGNED <u>10/10/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>87610 Carroll Ave Blkoma PK md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Oct. 13, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>	
23d. LOCATION CITY OR TOWN <u>Suitland, Maryland</u>					
24. FUNERAL DIRECTOR NAME <u>Stewart Funeral Home-4001 Benning Road, N.E.</u>		25. DATE REC'D. BY REGISTRAR <u>18 1984</u>		26. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

BP

1882



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

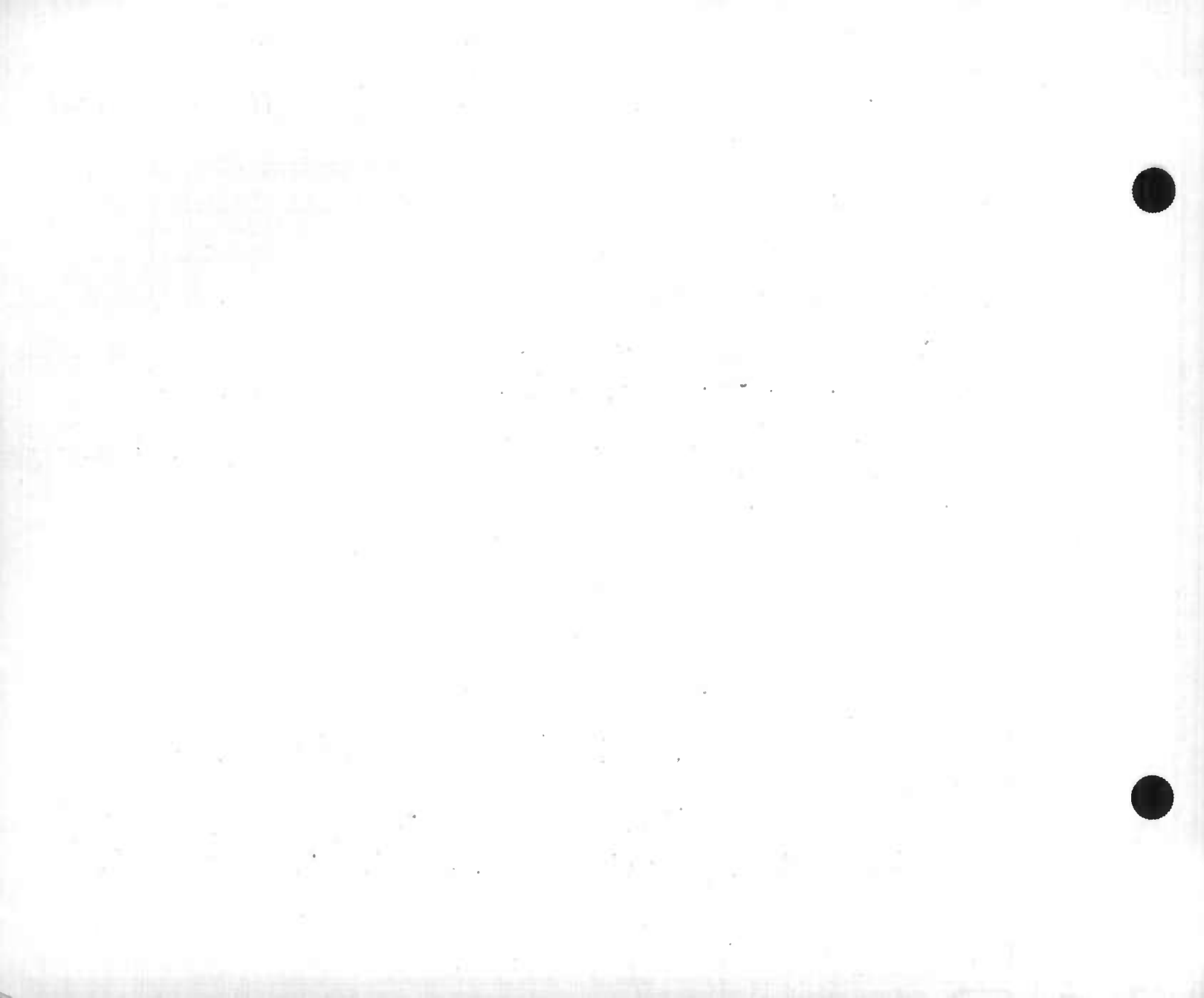
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					2 8 3 5 0				
1 - STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <u>Claude Albert Ducote</u>					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
							10 06 84		145P M
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
				MONTH DAY YEAR		45 YRS.		IF UNDER 24 HRS	
				February 13 1939				MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington, DC</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Prince Georges County</u>			
10 CITY OR TOWN OF DEATH <u>Morningside</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>6619 Woodland Road</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Accountant</u>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Pr. Georges</u>		13c. CITY OR TOWN <u>Morningside</u>		13e. STREET ADDRESS <u>20023 6619 Woodland Road</u>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>Albert Claude Ducote</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Edna Tyer</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>					16b. SOCIAL SECURITY NO <u>1959-1962 577-50-5353</u>				
					17 INFORMANT ADDRESS <u>Edna M. Ducote Same as #13</u>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant Astrocytoma</u>									<u>2 years</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>January 12, 19 84</u> to <u>October 6, 19 84</u> that (I/we) lost saw the deceased alive on <u>October 4, 19 84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard W. Holt MD</u>					DEGREE		22c. DATE SIGNED <u>10-06-84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RICHARD W. HOLT, MD</u>					22e. ADDRESS <u>3800 Reservoir Rd NW WASHINGTON DC</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>			23b. DATE <u>10-8-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland PG Md</u>		
24 FUNERAL DIRECTOR NAME <u>Robert E. Wilhelm</u>					24b. ADDRESS <u>Suitland, Md.</u>		25. DATE REC'D. BY REGISTRAR <u>OCT 9 1984</u>		
24c. FUNERAL HOME <u>Funeral Home</u>					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					2 8 3 5 1	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			
Thomas Greenfield Duvall			October 15, 1984			
3. SEX			4. RACE			
Male			White			
5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			
May 30, 1905			79 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			
Maryland			U. S. A.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
Clinton			Southern Md. Hospital Cntr			
12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			
Tobacco Warehousman			Tobacco Warehouse			
13a. STATE			13b. COUNTY			
Maryland			Pr. Geo's			
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Upper Marlboro			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
William Henry Duvall			Matilda Wood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			
No			220-12-2592			
17. INFORMANT			18. CAUSE OF DEATH			
Grace R. Duvall			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lt. Internal Carotid Art. Occlusion with DUE TO, OR AS A CONSEQUENCE OF Rt. hemiparesis (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of Prostateae with metastases			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) lost _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (solid) enter) _____			22b. DATE SIGNED			
22c. SIGNATURE			22d. ADDRESS			
Victor S. Chupkovich, M.D.			9131 Piscataway Rd., Clinton, Maryland --- Zip 22307			
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			
Burial			10/18/84			
23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
St. Thomas Cemetery			Croom (Pr. Geo's) Md.			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			
Richard A. Coleman - Upper Marlboro, Maryland 20772			NOV 1 1984			

October 14, 1981 1:00

White 30, 1981

James George

October 14, 1981 1:00

October 14, 1981 1:00

October 14, 1981 1:00

October 14, 1981 1:00

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October 14, 1981 1:00

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked "yes", injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 5 2

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			10			26			84			4:45AM					
3. SEX			Male			4. RACE			Caucasian			5. DATE OF BIRTH			MONTH			DAY			YEAR					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			Texas			7b. CITIZEN OF WHAT COUNTRY?			USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGE COUNTY			MD.					
10. CITY OR TOWN OF DEATH			CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			PRINCE GEORGE GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Administrator			12b. KIND OF BUSINESS OR INDUSTRY			US Government					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE											
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			YES			16b. SOCIAL SECURITY NO.			WW II			17. INFORMANT			12804 Kemper Lane			Bowie, Maryland			20715					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Cardiac arrest			DUE TO, OR AS A CONSEQUENCE OF			(b)			Myocardial Infarction			DUE TO, OR AS A CONSEQUENCE OF			(c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:			CARDIAC CECUMIA DUE TO PREVIOUS DISEASE			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			HOUR			A.M.			MONTH			DAY			YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from			10/20/84			19			to			10/26/84			19			that (I) (we) last saw the deceased alive on			10/20/84			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE			S. PUNJA			22c. DATE SIGNED			10/26/84			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			P. G. L. HOSPITAL			CHEVERLY			MD 20715					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			Burial			23b. DATE			October 30, 1984			23c. NAME OF CEMETERY OR CREMATORY			Baltimore National Cem.			Baltimore,			Maryland					
24. FUNERAL DIRECTOR			Beall Funeral Home			25a. DATE REC'D. BY REGISTRAR			NOV 2 1984			25b. REGISTRAR'S SIGNATURE			Julia Davidson-Randall											

Male	Christian	MAY 11, 1952	62
Texas	USA		
0-5-5114			
Maryland	Mr George's Bowie	XX	12004 Kemper Lane 20112
Prod	Kevin	Henry	John
12004 Kemper Lane 20112			
12004 Kemper Lane 20112	12004 Kemper Lane 20112	12004 Kemper Lane 20112	12004 Kemper Lane 20112
12004 Kemper Lane 20112	12004 Kemper Lane 20112	12004 Kemper Lane 20112	12004 Kemper Lane 20112

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28353

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNE SHEVLIN EVANS			2a. DATE OF DEATH MONTH DAY YEAR OCT. 28 1984			2b. HOUR 9:52A			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 15 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH W. HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2520 AVALON PLACE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES LADY		12b. KIND OF BUSINESS OR INDUSTRY SALES	
13a. STATE MD.			13b. COUNTY PR. GEO.		13c. CITY OR TOWN W. HYATTS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SHEVLIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRIDGET CAREY			16. STREET ADDRESS 2520 AVALON PL. HYATTSVILLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 209-18-1433		17. INFORMANT ADDRESS JOHN W. EVANS, 2520 AVALON PL. W. HYATTSVILLE				
18. CAUSE OF DEATH: (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cervical carcinoma Bil ducts DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a): Essential Hypertension									
19a. DATE OF OPERATION SEPT 14, 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Bil ducts, with metastasis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) attending physician attended the deceased from July 15 1959 to Oct 28 1984 , that (1) was last saw the deceased alive on October 27 1984 , and that in (my) my own opinion death occurred on the date and hour and from the causes stated above. (1) view did not view the body after death.									
22b. SIGNATURE John F. Brennan, Jr. MD				22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN F. BRENNAN, JR. M.D.				22d. ADDRESS 3415 HAMILTON ST. HYATTSVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 1984		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Md		23e. DATE OF INTERMENT Oct 28, 1984	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, J.G. Klueter				ADDRESS 254 CONNERSVILLE RD		25. DATE OF INTERMENT Oct 28, 1984			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

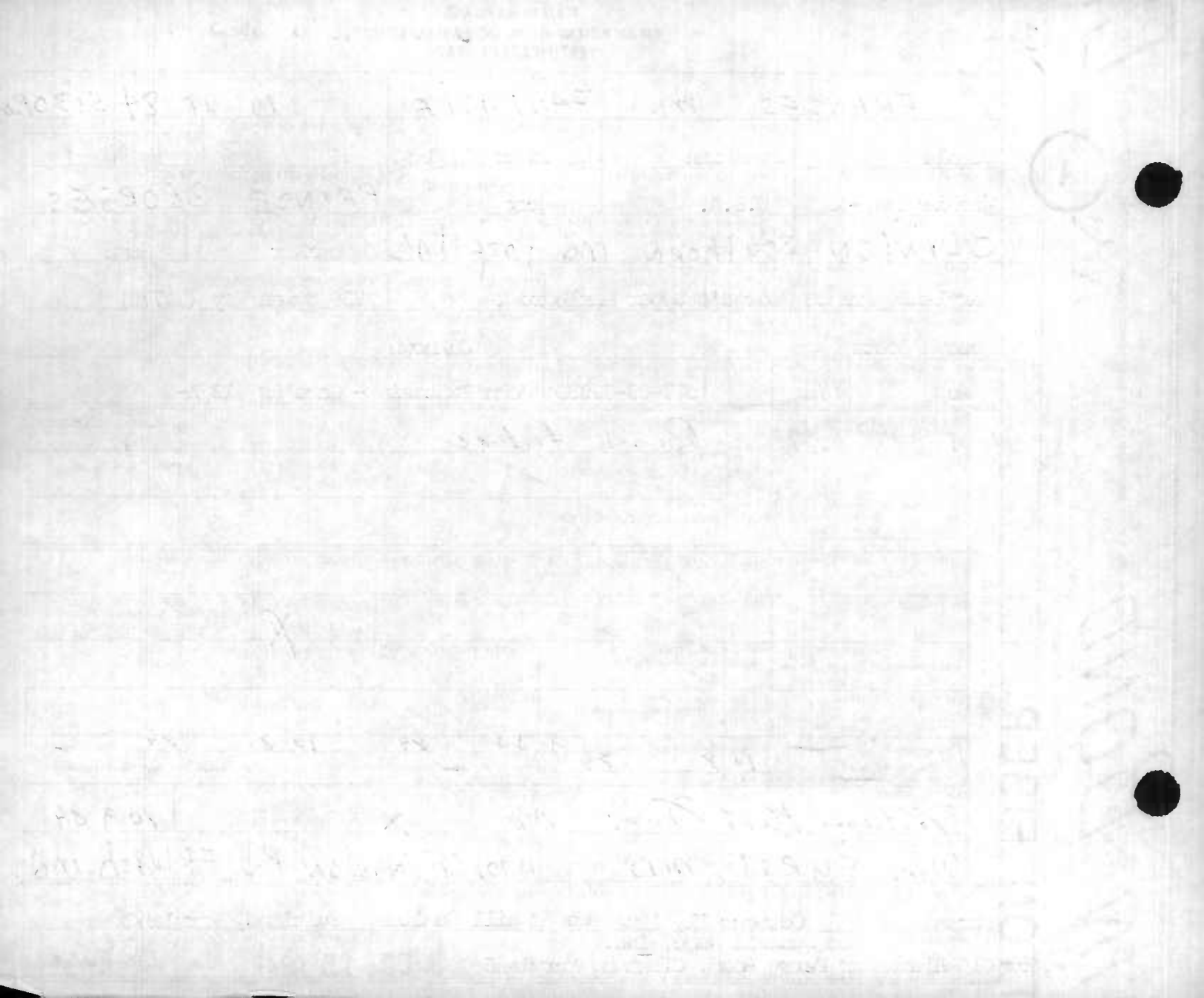
2 8 3 5 4

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCES M. FANTASIA			2a. DATE OF DEATH MONTH DAY YEAR 10 08 84			2b. HOUR 5:30 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 31, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 9739 Wyman Way (20772)	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Goetz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS John Fantasia - Same As #13 A-E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 9-30 , 19 84 , to 10 8 , 19 84 , that (I) (we) last saw the deceased alive on 10 8 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE William Kent Junt				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10 9 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. FURST MD				22e. ADDRESS 11701 Livingston Rd. Ft. Wash. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE S. Davidson-Randall			
NAME Old Alexander Ferry Road, Clinton, Maryland				ADDRESS					

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28355

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER D FERREBEE			2a. DATE OF DEATH MONTH DAY YEAR OCT. 31 89			2b. HOUR 6¹⁰ PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCT 6, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Locksmith		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN LaPlata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 2 Box 2136 20646			
14. FATHER'S NAME FIRST MIDDLE LAST Luther D. Ferree				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda E. Leatherman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II				16b. SOCIAL SECURITY NO. 233 092280		17. INFORMANT ADDRESS Betty J. Ferree Rt 2 LaPlata, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF MULTIPLE ORGAN FAILURE AND SEPSIS (b) AND SEPSIS DUE TO, OR AS A CONSEQUENCE OF MALIGNANT CARCINOID OF RECTOSIGMOID WITH METASTASES (c) OF RECTOSIGMOID WITH METASTASES										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ACUTE CACHEXIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-13 , 19 89 , to 10-31 , 19 89 , that (I) (we) last saw the deceased alive on 10-31 , 19 89 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Daniilo G. Lee MD				DEGREE MD				22c. DATE SIGNED 10-31-89			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANILO G. LEE				22e. ADDRESS 7700 OLD BRANCH AVENUE CLINTON, MD 20735							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5 Nov 84		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W.Va.			
24. FUNERAL DIRECTOR NAME ADDRESS RoTruck Funeral Home Keyser W.Va.				25a. DATE REC'D. BY REGISTRAR NOV 5 1984		25b. REGISTRAR'S SIGNATURE John Davidson					

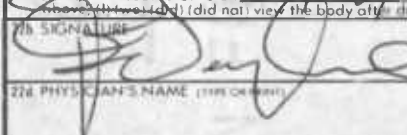
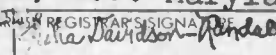
BP

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					2. REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT C. FEWELL					2a. DATE OF DEATH MONTH DAY YEAR HOUR 10 25 84 7 03PM_M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4--25---31		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 53 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Franklin, Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Cab. Maker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Forrestville		13e. STREET ADDRESS / ZIP CODE 5296 Marlboro Pike. #107			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Fewell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dunlap					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 579-38-1829		17. INFORMANT ADDRESS Seat Plast Nancy Fewell 7022 Cayon Dr. Md. 20743			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Uncontrolled Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from 10/25/84 to 10/25/84 , that (i) (we) last saw the deceased alive on 10/25/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we did not view the body after death, so state).									
22b. SIGNATURE 				22c. DATE SIGNED 10/25/84				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. [Name]	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 30, 84		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, P.G. Maryland			
24. FUNERAL DIRECTOR Comer-Hodges				25a. DATE RECEIVED BY REGISTRAR OCT 31 1984		25b. REGISTRAR'S SIGNATURE 			

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 5 7	
1. DECEASED NAME (TYPE OR PRINT) Edward Paul FLAHERTY			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10-5 1984			2b. HOUR M 9:5					
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11-26-34	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 49	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-5 1984		2d. HOUR M 9:5			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marketing		12b. KIND OF BUSINESS OR INDUSTRY Gas			
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12412 Shelter Lane 20715		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Case Flaherty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith D. Winland							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1957 - 1959		17. INFORMANT Shirleyann Flaherty		ADDRESS 12412 Shelter Lane Bowie, MD 20715				
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden chronic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 10-5-84		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Prince George's, MD			
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Rd. Bowie, MD 20715			25a. DATE REC'D. BY REGISTRAR OCT 9 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Their please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edith Fleming</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 30 84</i>			2b. HOUR <i>5 50</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 12 1880</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>104</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Brownsville, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>P.G.</i> MD.			
10. CITY OR TOWN OF DEATH <i>LARGO</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MANOR CARE LARGO</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1001 Chillum Rd #408 20779</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert Watson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Wilma Adolfsen</i>		16. ADDRESS <i>600 Largo Rd.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212-56-2314</i>		17. INFORMANT <i>MCL</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Constrictive Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>10/1/84</i> 19 <i>84</i> to <i>10/30/84</i> 19 <i>84</i> , that (I) was lost saw the deceased alive on <i>10/30</i> 19 <i>84</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Meade</i>			22c. ADDRESS <i>und</i>			22d. ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>10/30/84</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>10-30-84</i>			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>STATE ANATOMY BOARD</i> ADDRESS <i>Baltimore, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>NOV 2 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO. 8 3 5 9	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST MELVIN GARDNER		X MONTH DAY YEAR 10 7 19 84	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Male	Black	1- 16-1950	34 YRS.
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
N.C.	USA	X NEVER MARRIED	Prince George's County
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cheverly	Prince George's Gen. Hosp.	Parking Attendant	Pvt.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Md.	P.G.	Hyattsville	YES X NO
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
Felix	Mary	5504 Newton Street 20784	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	238-80-4162	Elvin Gardner	5504 Newton St.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	12:55xx 10-7- 84	Pedestrian struck by auto.	
21d. INJURY OCCURRED WHILE AT WORK X NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION	21g. COUNTY
	road	Balto.-Wash. Pkwy.	Prince George's
22a. I certify that I took charge of the remains described above, held on death resulted from		22b. Inspection X In my opinion	
Natural causes X Accident X Suicide Homicide Undetermined manner			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Ann M. Dixon, M.D.		Assistant	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
111 Penn St., Balto., Md. 21201		10-7-84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Removal	10/12/84	Mitchell Funeral Home	Lagrange, North Car.
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Alexander S. Pope	2617 Penn. Ave.,		Oct. 19 1984 Julia Davidson-Rendell

10-10-1961

10-10-1961

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10-10-1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28360

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE D LAST GAY			2a DATE OF DEATH MONTH DAY YEAR 10 08 84			2b HOUR 11:30am			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov 8 1902		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b KIND OF BUSINESS OR INDUSTRY Buckner Foundation	
13a STATE Florida				13b COUNTY Jacksonville		13c CITY OR TOWN Jacksonville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Franklin Duncan				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corrie Drake					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. -- 045-26-2145		17 INFORMANT Nancy Sipes/Niece			
18a ADDRESS 4006 Murdock St				18b ADDRESS Temple Hills, Md					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS DUE TO, OR AS A CONSEQUENCE OF (c) GASTRIC SURGERY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		

MEDICAL CERTIFICATION

19a DATE OF OPERATION 8/26/84		19b CONDITION FOR WHICH OPERATION WAS PERFORMED upper G. & B. bleeding		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 8/23/84 19 to 10/17/84 19, that (I) (we) lost saw the deceased alive on 10/17/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.							
22b SIGNATURE Surgeon J. Patel MD						22c DATE SIGNED 10/8/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. PATEL MD						22e ADDRESS 10905 Ft. Wash. Rd. Ft. Wash. Md.	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-15-84		23c NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Jacksonville Fla	
24 FUNERAL DIRECTOR FRAMER Robert E. Wilhelm Funeral Home				25a DATE REC'D. BY REGISTRAR OCT 9 1984		25b REGISTRAR'S SIGNATURE Jana Davidson-Randall	

1

APR 24 1964

1. The first part of the report is a description of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained. The second part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained.

2. The second part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained. The third part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained.

3. The third part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained. The fourth part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained.

4. The fourth part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained. The fifth part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained.

5. The fifth part of the report is a discussion of the work done during the last year. This includes a list of the projects completed and a summary of the results obtained.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

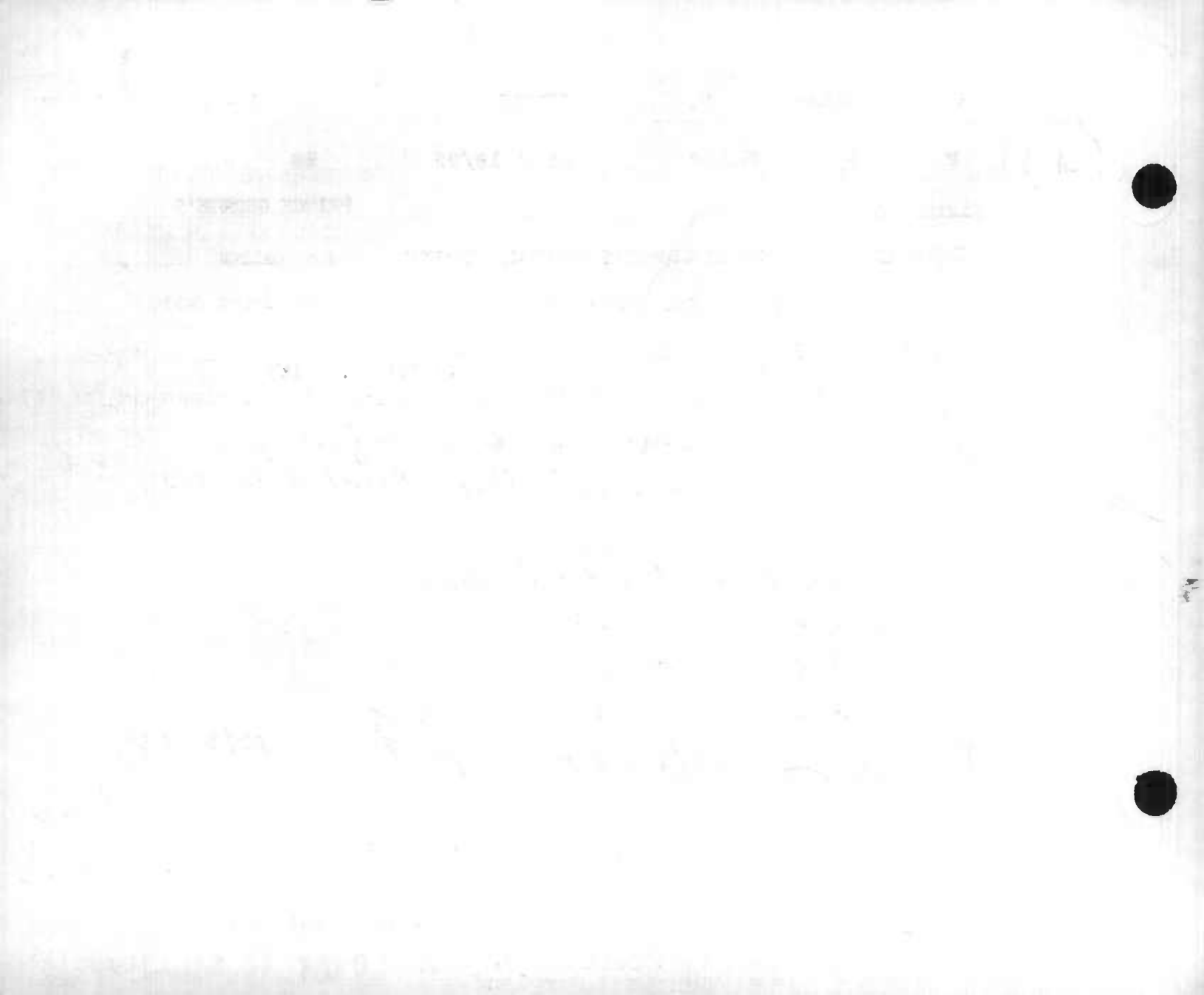
28361

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BEULAH V. GENTLE			2a. DATE OF DEATH MONTH DAY YEAR 10-02-84		2b. HOUR I 59PM							
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 / 18/95		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD			13b. COUNTY PG		13c. CITY OR TOWN St. Plesant		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6108 Addison Road 20743			
14. FATHER'S NAME FIRST MIDDLE LAST Ira D Reynolds			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza A Neale									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-54-5077			17. INFORMANT Lucille G. Smith 6108 Addison Rd St Pleasant MD 2074						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>uncontrolled atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3-4 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>congestive heart failure</u>												
19a. DATE OF OPERATION <u>none</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>N.A.</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>N.A.</u>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK <u>N.A.</u>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N.A.</u>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N.A.</u>						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> 19 <u>84</u> , to <u>10/2</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/2</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>e. Soriano</u>			DEGREE <u>MD.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10/2/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CESAR SORIANO JR</u>			22e. ADDRESS <u>119 CAPITOL HEIGHTS BLVD. CAPITOL HEIGHTS, MD. 20743</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>10/6/84</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland PG MD</u>			
24. FUNERAL DIRECTOR NAME <u>Robert E Wilhelm</u>						ADDRESS <u>4308 Suitland Rd</u>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>OCT 10 1984 Julia Davidson-Rendell</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 6 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT Littleton GILCHRIST			2a. DATE OF DEATH MONTH OCTOBER DAY 9 YEAR 1984			2b. HOUR A MIN 11:20	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH Feb. DAY 2 YEAR 1931		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY DC Pk Svc	
13a. STATE D.C.		13b. COUNTY - -		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Willie MIDDLE Gilchrist LAST Gilchrist		15. MOTHER'S MAIDEN NAME FIRST Ethel MIDDLE Thomas LAST Thomas		13e. STREET ADDRESS / ZIP CODE 405 60th Street N.E. 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1952-54		17. INFORMANT Bernice Gilchrist		ADDRESS same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Probable Ventricular Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) organic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 + years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). chronic Renal failure, Peritonitis.							
19a. DATE OF OPERATION 10/8		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/8 , 19 84 to 10/9 , 19 84 , that (I) (we) last saw the deceased alive on 10/9 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE Steven M. Pollak		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven M. Pollak, M.D.		22e. ADDRESS 4700 Auth Place #200, Camp Springs, Md. 20023					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-13-84		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem.		23d. LOCATION CITY OR TOWN Suitland, Md. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home ADDRESS 4217 9th St NW: Washington, D.C.				25a. DATE REC'D. BY REGISTRAR OCT 15 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

DHMH, 16 50M 4/83
(VRA 15-4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH R. GOODE					2a. DATE OF DEATH October 2, 1984			2b. HOUR 9:00 AM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH June 15, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.						
10 CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Paint Branch Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lost & Found			12b KIND OF BUSINESS OR INDUSTRY Hotel			
13a STATE Virginia				13b COUNTY Arlington		13c CITY OR TOWN Arlington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3602 N 14th St. 99999		
14 FATHER'S NAME FIRST MIDDLE LAST Joseph A. Godfrey				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Vojnik								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT 3107 Fallston Ave. Martha A. Nilles Beltsville, Md. 20705						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ischemic heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Organic brain syndrome</u>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (1) (this hospital) attended the deceased from <u>9/24/84</u> to <u>10/2/84</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (a) signed, did not view the body after death.)												
22b. SIGNATURE <u>Peter M. Schissler</u>						DEGREE <u>MD</u>		22c. DATE SIGNED <u>10/3/84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter M. Schissler, M.D.						22e ADDRESS Greenway Center Drive #430 Greenbelt, Maryland 20770						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/6/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Staubenville, Jefferson Ohio				
24 FUNERAL DIRECTOR FLOCK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707						25a. DATE REC'D. BY REGISTRAR OCT 4 1984		25b. REGISTRAR'S SIGNATURE <u>Juha Davidson-Randall</u>				

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified online.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 2 8 3 6 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Donald M GORE				October 7, 1984			
2b. HOUR 5:50P M							
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 20 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Residence of P.G. County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply Manager		12b. KIND OF BUSINESS OR INDUSTRY Hecht Company	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Gore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Letoa Holland		13e. STREET ADDRESS / ZIP CODE 6615 Stanton Road 20784			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Army		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 176-03-3702		17. INFORMANT ADDRESS Lowine M. Gore (Wife) Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with carcinoma metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>h</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>h</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>h</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>83</u> to <u>Oct</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>OCT 7</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Martin S. Wertz		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin Wertz 7676 New Hampshire Avenue Langley Park MD 20783		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/7/84		23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Maryland	
24. FUNERAL DIRECTOR NAME F. asch's Sons F.H. P.A. Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 11 1984 John Davidson-Rendell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove transportation. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 50M 4/83

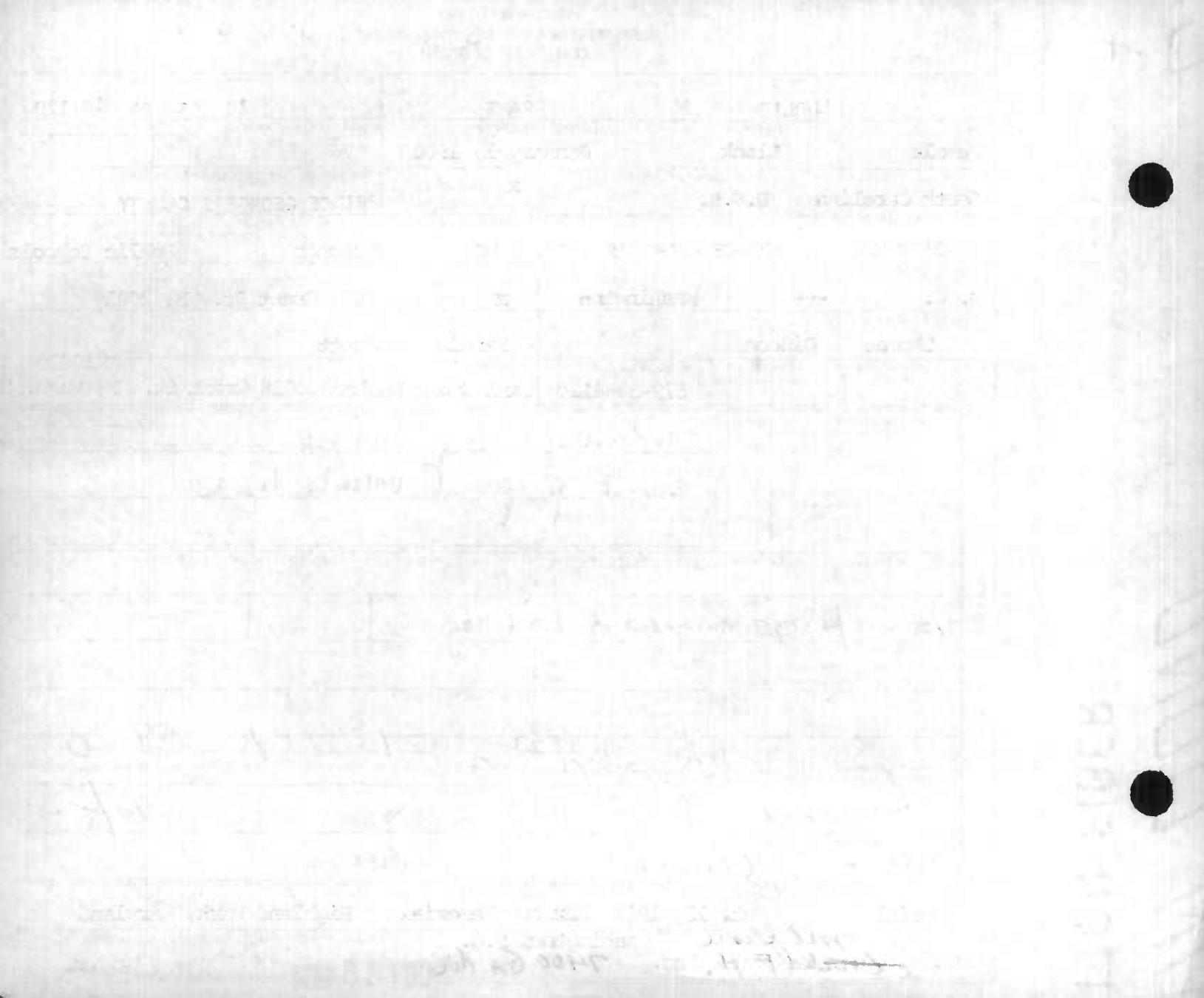
(VRA 15, 4)

#5, F ImG610 12/4/85 kam

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2 8 3 6 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LURLIE M GRANT		2a. DATE OF DEATH MONTH DAY YEAR 10 05 84 2b. HOUR 10:12 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR January 31 1908 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSP. & MC	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher 12b. KIND OF BUSINESS OR INDUSTRY Public Schools	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D. C. 13b. COUNTY		13c. CITY OR TOWN Washington 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 4038 Grant St. NE, 20019	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Gideon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Scott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-38-4120 17. INFORMANT Earl Grant, husband, 4038 Grant St. NE, Wash. DC 20019	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe peripheral vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION 9/28 - 10/4 - 10/5		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene of Left leg	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/5/84 to 10/5/84, that (I) (we) lost saw the deceased alive on 10/5/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Bruce G. Lowman MD.		22c. DATE SIGNED 10/5	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE G. LOWMAN		22e. ADDRESS PGGN.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 13, 1984	
23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Highland Park, Maryland	
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc.		25a. DATE REC'D. BY REGISTRAR OCT 15 1984	
25b. REGISTRAR'S SIGNATURE John K. Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charlie Charles Green				2b. DATE OF DEATH MONTH DAY YEAR October 24, 1984			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Maintenance	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY P. George		13c. CITY OR TOWN Laurel	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown - Green				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown - Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 400-14-7317A		17. INFORMANT Ruth Green		ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC SQUAMOUS CELL CARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Aug 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/24 19 84 , to Oct 19 84 , that (I) (we) lost saw the deceased alive on 10/24 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE ES MACHADO				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ES MACHADO				22e. ADDRESS 321 PRINCE GEORGE ST			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY SEALS FARM		23d. LOCATION CITY OR TOWN COUNTY STATE ETCHISON MONT. MD.	
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER				LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR OCT 29 1984	
				25b. REGISTRAR'S SIGNATURE J. Davidson-Rodden			

BP _____



BP

DHMM - 17
(VR A15 ME (1))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 5 7							
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH						2b. HOUR					
1 DECEASED NAME (TYPE OR PRINT) Gordon Henry GREEN						2c. DATE ESTIMATED 10-17-84						2d. HOUR 9:15					
3 SEX Male		4 RACE White		5. DATE OF BIRTH 10-14-12		6. AGE IN YEARS (LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2e. DATE PRONOUNCED DEAD 10-17-84		2f. HOUR 14			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada				7b CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges					
10 CITY OR TOWN OF DEATH Forestville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 3739 Donnell Drive 301				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative Officer				12b KIND OF BUSINESS OR INDUSTRY U S Gov't					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a STATE Maryland				13b COUNTY PG				13c CITY OR TOWN Forestville					
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS 3739 Donnell Drive 20747													
14. FATHER'S NAME John Albert Green						15. MOTHER'S MAIDEN NAME Jane Ann Murray											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes						16b. SOCIAL SECURITY NO. 521-03-3133						17. INFORMANT ADDRESS 208 N. 2nd St Oakland, Md.					
16c. (IF YES, GIVE WAR OR DATES) WWII																	
18. CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 10-17-84					
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/20/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d LOCATION CITY OR TOWN Suitland COUNTY PG STATE Md							
24 FUNERAL DIRECTOR NAME Robert E. Wilhelm ADDRESS Suitland, Md.						25a DATE REC'D. BY REGISTRAR OCT 23 1984		25b REGISTRAR'S SIGNATURE John William Rodella									

GREEN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					2 8 3 6 8					
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Ivan GREENE					2a. DATE OF DEATH MONTH DAY YEAR October 21, 1984				2b. HOUR 11:24 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Car Salesman		12b. KIND OF BUSINESS OR INDUSTRY Bill Greene Motors		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY P.G.		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Greene					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Haynes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Army					16b. SOCIAL SECURITY NO. 226-24-0144		17. INFORMANT ADDRESS Ann Clayton 9809 Branchview Dr. Fort Washington, Md. 20744			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage 2° of left branch pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF <i>DIC & Renal failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>General peritonitis 2° of perforation</i> DUE TO, OR AS A CONSEQUENCE OF <i>General peritonitis 2° of perforation</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 84 , to 10/21 , 19 84 , that (I) (we) last saw the deceased alive on 10/21 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edward Gherer</i> DEGREE Pathologist					22c. DATE SIGNED 10/22/84					
22d. PHYSICIAN'S NAME (LAST OR FIRST) <i>Edward Gherer M.D.</i>					22e. ADDRESS Doctors' Hospital of Pr. Geo. Co. Lanham, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 26, 1984		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bristol Sullivan Tenn.				
24. FUNERAL DIRECTOR (NAME) F. Gasch's Sons F.H. P.A. Hyattsville, Maryland					25a. DATE REC'D. BY REGISTRAR 125, 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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Ward Washington, Md. 20744
9800 Massachusetts Dr
Hyattsville

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1410-42-029

1997-1998 1998-1999

Oct. 26, 1864 - Howard Cemetery

7. Coach's Name: Mr. J. J. [illegible], Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 6 9
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles GROOMS			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 10-5-84			2b. HOUR M <input checked="" type="checkbox"/> 10-5-84 9:30		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 6-3-04 80 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 10-5-84 9:30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Navy Yard		12b. KIND OF BUSINESS OR INDUSTRY US Gov't		
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William F. Grooms		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Luders		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. ---		17. INFORMANT Marie Staats		ADDRESS Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemic candidiasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez		M.D. Deputy		MEDICAL EXAMINER			DATE SIGNED 10-6-84	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 10, 84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home Suitland, Md.				25a. DATE REC'D. BY REGISTRAR OCT 9 1984		25b. REGISTRAR'S SIGNATURE [Signature]		

Approved: J. Edgar Hoover, Director, Federal Bureau of Investigation, U.S. Department of Justice

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 7 0
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT M. GROVES			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 10-4-84		2b. HOUR 19
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH April DAY 22 YEAR 1936	6. AGE (IN YEARS) LAST BIRTHDAY 48 YRS.	IF UNDER 1 YR. MONTHS 48 DAYS 48 HOURS 48 MIN.	IF UNDER 24 HRS. MONTHS 48 DAYS 48 HOURS 48 MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Installer	
13a. STATE Maryland		13b. CITY OR TOWN Montgomery Silver Spring		13c. STREET ADDRESS 12808 Maple Street 20906	
14. FATHER'S NAME FIRST Alexander MIDDLE - LAST Groves			15. MOTHER'S MAIDEN NAME FIRST Eva MIDDLE A. LAST Beaman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Nat. Gaurd 219-34-8439		17. INFORMANT ADDRESS Kathleen Groves Same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Margareta A. Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER DATE SIGNED 10-5-84	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/8/84		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME INC. ADDRESS 7601 Sandy Spring Rd. Laurel, Md.		25a. DATE REC'D. BY REGISTRAR OCT 9 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
23d. LOCATION CITY OR TOWN Burtonsville, Maryland		COUNTY STATE			

2000



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				2 8 3 7 1			
1. FOR STATE REGISTRAR				REG. NO.			
2. DECEASED NAME (TYPE OR PRINT) Wendell Eugene Hahn				2a. DATE OF DEATH October 15, 1984		2b. HOUR 7:15PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH October 24, 1927		6. AGE (IN YEARS EAST BIRTHDAY) 58 56 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Management Specialist		12b. KIND OF BUSINESS OR INDUSTRY Dept. of the Army	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George's 13c. CITY OR TOWN Camp Springs				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7207 Shockley Court (20744)	
14. FATHER'S NAME George Hahn		15. MOTHER'S MAIDEN NAME Gladys Mc Lain		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 1947-1950			
16b. SOCIAL SECURITY NO. 006-22-8845		17. INFORMANT Wendell Hahn, Jr.		ADDRESS Route 2, PO Box 109 Charlotte Hall, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lt. Internal Carotid Artery Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) General Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. H.A.C.V.D.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/12/84 to 10/15/84, that (I) (we) lost saw the deceased dying on 10/15/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (read) (and) (not) view the body after death.							
22b. SIGNATURE Victor S. Chupkovich, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor S. Chupkovich, M.D.				22e. ADDRESS 9131 Piscataway Road Clinton, Maryland 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 18, 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery, Cheltenham, MD		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS Old Alexander Ferry Road, Clinton, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 23 1984		25b. REGISTRAR'S SIGNATURE Ala Davidson-Randall	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 2-101 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 7 2	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Louis Hall Sr.						2a. DATE OF DEATH KNOWN ESTIMATED 10-29 19 84		2b. HOUR 7:56 a.m.			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1935		6. AGE (IN YEARS) LAST BIRTHDAY 48 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 10-29 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY P.G. Gov't	
13a. STATE Maryland				13b. CITY P.G.		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13209 Croom Road 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Percy Allen Hall						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Aminett Boswell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-50-9204		17. INFORMANT ADDRESS Margaret V. Hall same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:01am 10-29 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/fixed object impact					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9360 D'Aray Road, Forestville, Prince George's Co., Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>						TITLE (SPECIFY) Assistant			DATE SIGNED 10-29-84		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS 111 Penn Street, Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-2-84		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, P.G.. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Maryland						25a. DATE REC'D. BY REGISTRAR NOV 1 1984		25b. REGISTRAR'S SIGNATURE <i>Ma Davidson-Rendell</i>			

BP

1938 Nov. 17, 1938

U.S.A.

Supervisor

Under Review

U.S.A.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4-82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 7 3 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Joseph J. Hamilton								7a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 10-20 19 84		7b. HOUR 4:00 a.m.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 28 55		6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 10-20 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 214 near Hall Road					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Snowden & Sons	
13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7240 Landover Road #E 20785			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Hamilton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Spriggs				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			
				16b. SOCIAL SECURITY NO. 1975-1981		17. INFORMANT Robin G. Hamilton		ADDRESS 7240 Landover Rd #E Landover, MD 20785			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt Head Trauma 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:00am 10-20 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto(s)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 214 near Hall Road, Prince George's Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 10-20-84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10/23/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD			
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. ADDRESS 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019						25a. DATE REC'D. BY REGISTRAR OCT 23 1984		25b. REGISTRAR'S SIGNATURE <i>P. J. ...</i>			

ROLLINS FUNERAL HOME, INC.
4339 HUNT PLACE, N.E.
WASHINGTON, D.C. 20015

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN AUTOPSY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, 3, 4, 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH - WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WESTPONT STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BF

DHMH - 17
VR A15 ME (5)
20M 4/82

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR					
MARGARET R. HAMILTON						10-9		1984					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
FEMALE		WHITE		Oct. 31, 1903		80 YRS.				10-9		1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH	
New Jersey				U.S.A.				WIDOWED				PRINCE GEORGES	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly				PRINCE GEORGES GENERAL HOSPITAL				Clerk				U.S. Gov't.	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				P.G.		Hyattsville		YES		3405 Jefferson Street 20782			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
John Atkins				Jessie Young									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS					
No				577-05-3323				Mrs. Martha K. Hamilton No# 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: 8842 IMMEDIATE CAUSE (a) RIGHT HIP FRACTURE WITH COMPLICATIONS													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED					
2:30 P.M. 9-29 1984				FELL WHEN TRYIN TO GET INTO A WHEELCHAIR									
21d. INJURY OCCURRED WHILE AT WORK				21e. PLACE OF INJURY				21f. LOCATION				21g. CITY OR TOWN	
NURSING HOME				1801 MEZEROTT RD. ADELPHI, PR.				GEORGES, MD					
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.													
23a. ACTUAL SIGNATURE				23b. TITLE (SPECIFY)				23c. DATE				23d. MEDICAL EXAMINER	
Augusto P. Rodriguez				Deputy				10-10-84					
23e. EXAMINER'S NAME				23f. ADDRESS									
Augusto P. Rodriguez, M.D.				5009 Rayburn Ct., Temple Hills, Md.									
23g. BURIAL, CREMATION, REMOVAL				23h. DATE				23i. NAME OF CEMETERY OR CREMATORY				23j. LOCATION	
Cremation				Oct. 11, 1984				Ft. Lincoln Crematory				Brentwood	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				OCT 15 1984				Julia Davidson-Rendell					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Dr. Rodriguez notified. OK to

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										2 8 3 7 5	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel B. Harrison					2a. DATE OF DEATH MONTH DAY YEAR 10 3 84			2b. HOUR 6:40 AM			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2 12 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Pr. George		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5507 Madison St. 20840			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Motter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Rosenstell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-52-3255		17. INFORMANT ADDRESS Wm. F. Harrison, Jr. 6812 Leyte Dr. Oxon Hill Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 4 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/20, 1984 to 10/3, 1984 that (I) (we) last saw the deceased alive on 10/3, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Robert M. Nedzbala				DEGREE M.D.				22c. DATE SIGNED 10/3/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. Nedzbala, M.D.				22e. ADDRESS 11701 Livingston Rd. Ft. Washington, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/4/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR OCT 8 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpanpapers; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR		MONTH DAY MIN.	
JAMES HARRISON			10 21 84		8:46AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
male	Black	Feb. 26 1920	64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
South Carolina	U.S.A.		PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON	Southern Md Hospital		Presser		Palace laundry	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE			
DC, D.C.	Washington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1024 - 4th ST, SE. #22			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME					
Joseph Harrison	Mande Longstreet					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS		
Yes	W.W.II	Lorraine Wilkins		1024-4th ST SE. #22 Wash DC.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) cardio-respiratory arrest						
DUE TO, OR AS A CONSEQUENCE OF (b) septic shock						
DUE TO, OR AS A CONSEQUENCE OF (c) Gastric Perforation						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Pneumothorax, Pneumoperitoneum, Acute renal failure, Diabetes mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR				
		P.M. 19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-19-84 to 10-21-84, that (I) (we) last saw the deceased alive on 10-21-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
MAHESH CHANDRA, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		10-21-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
		9131, Piscataway Rd, Clinton, MD 20735				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial	10-26-84	Harmony Mem. Park		Lanham P.G. Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W.W. Chambers CO INC		517 11th ST. SE Wash DC 20003		Jill Davidson-Randall		

W. J. Chambers, 2111 21st St. N.W.,
2003

Born 10-20-24, Harmon, Me. Ark. Landon, Pa. and

10-20-24, Harmon, Me. Ark. Landon, Pa. and

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28377

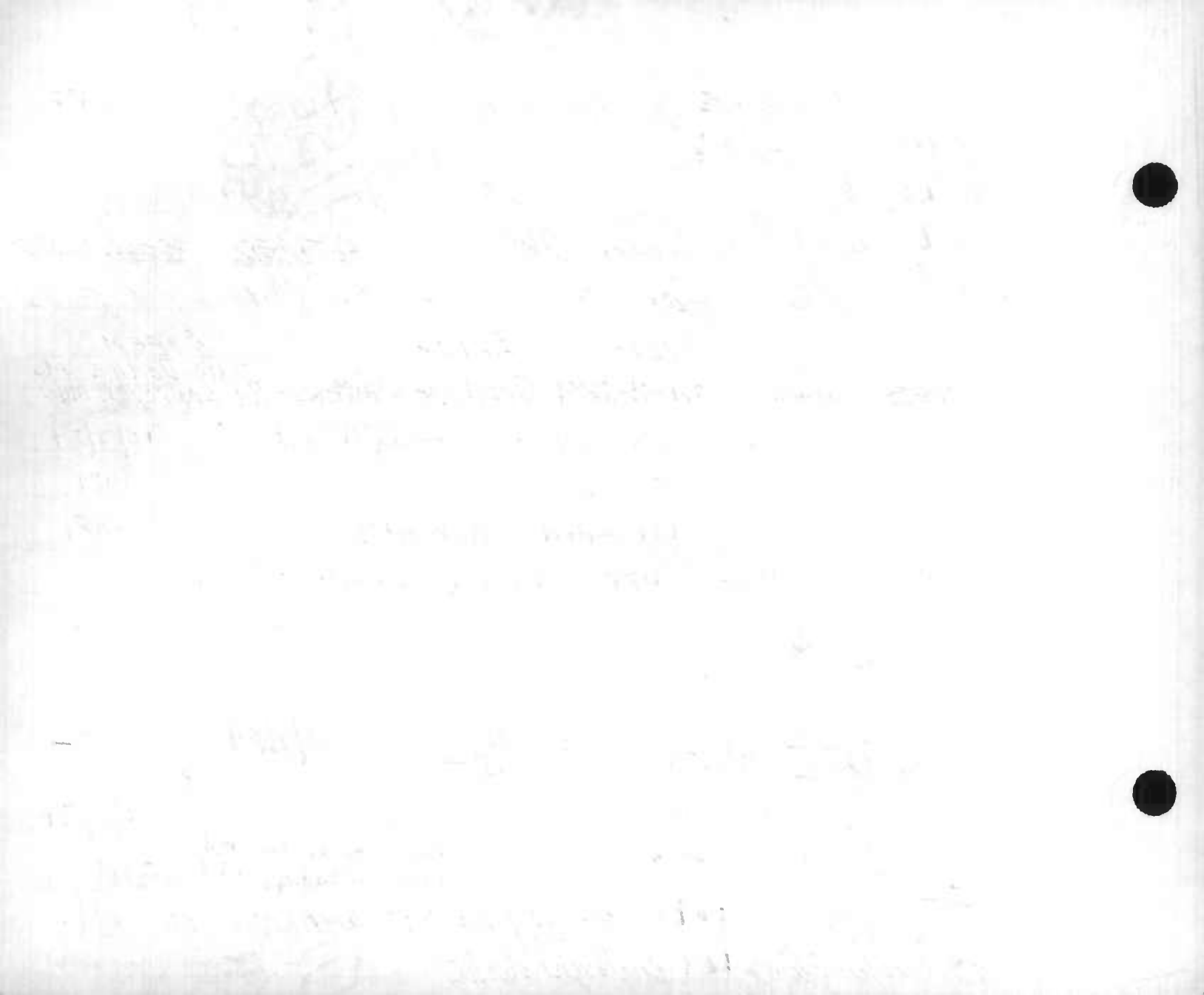
FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARENCE HARRON			2a. DATE OF DEATH 10/7/84		2b. HOUR 2:40P M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 8 - DAY 7 - YEAR 07	6. AGE 77 YRS.	7. IF UNDER 1 YEAR MONTHS 77 DAYS 77 HOURS 77 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lanham Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.		
10. CITY OR TOWN OF DEATH Delphi Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Hds.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL BOARD
13a. STATE Md			13b. COUNTY P.G.		
13c. CITY OR TOWN Delphi			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 3510 Hubert Rd 20785					
14. FATHER'S NAME FIRST Robert MIDDLE HARRON LAST HARRON			15. MOTHER'S MAIDEN NAME FIRST ELIZA MIDDLE QUEEN LAST QUEEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 214-05-2689		
17. INFORMANT GERTRUDE WRITERS - Rd. LANOVER Md.			ADDRESS 3410 Dodge PK		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardropulmonary Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/7/84	
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD				1981	
DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatoid Arthritis				1981	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 410 Peptic Ulcer, HBP, Anemia, Senile Dementia					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) the hospital attended the deceased from 5/12/81 , 19____, to 10/7/84 , 19____, that (2) the doctor saw the deceased alive on 10/5/84 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) and (2) and not view the body after death.					
22b. SIGNATURE MB Patrick MD		DEGREE		22c. DATE SIGNED 10/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick MD		22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-12-84		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PK	
23d. LOCATION CITY OR TOWN HIGHLAND PK COUNTY MD STATE		23e. DATE REC'D BY REGISTRAR 10/11/84			
24. FUNERAL DIRECTOR NAME H.S. Washington & Sons - Burroughs Ave NE ADDRESS 4925 N. H.		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				28378			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND A. HAWK				2a. DATE OF DEATH MONTH DAY YEAR 10-03-84		2b. HOUR 2:15AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH July 28, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Linotype Operator		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Greenbelt	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar A. Hawk				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie T. Hutton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Lauretta H. Mozingo - above address (Dtr.)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CARCINOMA OF RIGHT LUNG DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-29-1984 to 10-3-1984, that (I) (we) last saw the deceased alive on 10-2-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE N.B. Vellanki				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.B. VELLANKI MD.				22e. ADDRESS P99H 9 Hc, CHEVERLY, MD. 20785.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/8/1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		ADDRESS Mt. Rainier Md.		25a. DATE REC'D. BY REGISTRAR OCT 10 1984		25b. REGISTRAR'S SIGNATURE Julia Swanson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 7 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Bruce Henderson			2a. DATE OF DEATH MONTH DAY YEAR October 6, 1984		2b. HOUR 12:27A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 14 th 1931 st	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hsopital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Constructio	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN New York Suffolk Huntington			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE 43 Penataquit Place 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Henderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Gairn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) KOREA 059-24-8040	17. INFORMANT ADDRESS Josephine Henderson Same as #13c		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

SEPSIS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 DAYS 10 HRS

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c) CHRONIC LYMPHOBLASTIC LEUKEMIA

3 DAYS

3 YRS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/5, 19 84, to 10/6, 19 84, that (I) (we) saw the deceased alive on 10/5, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE R. MAGGIN		DEGREE MD		22c. DATE SIGNED 10/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MAGGIN		22e. ADDRESS 14333 LAUREL SOWIE RD LAUREL, MD. 20708			

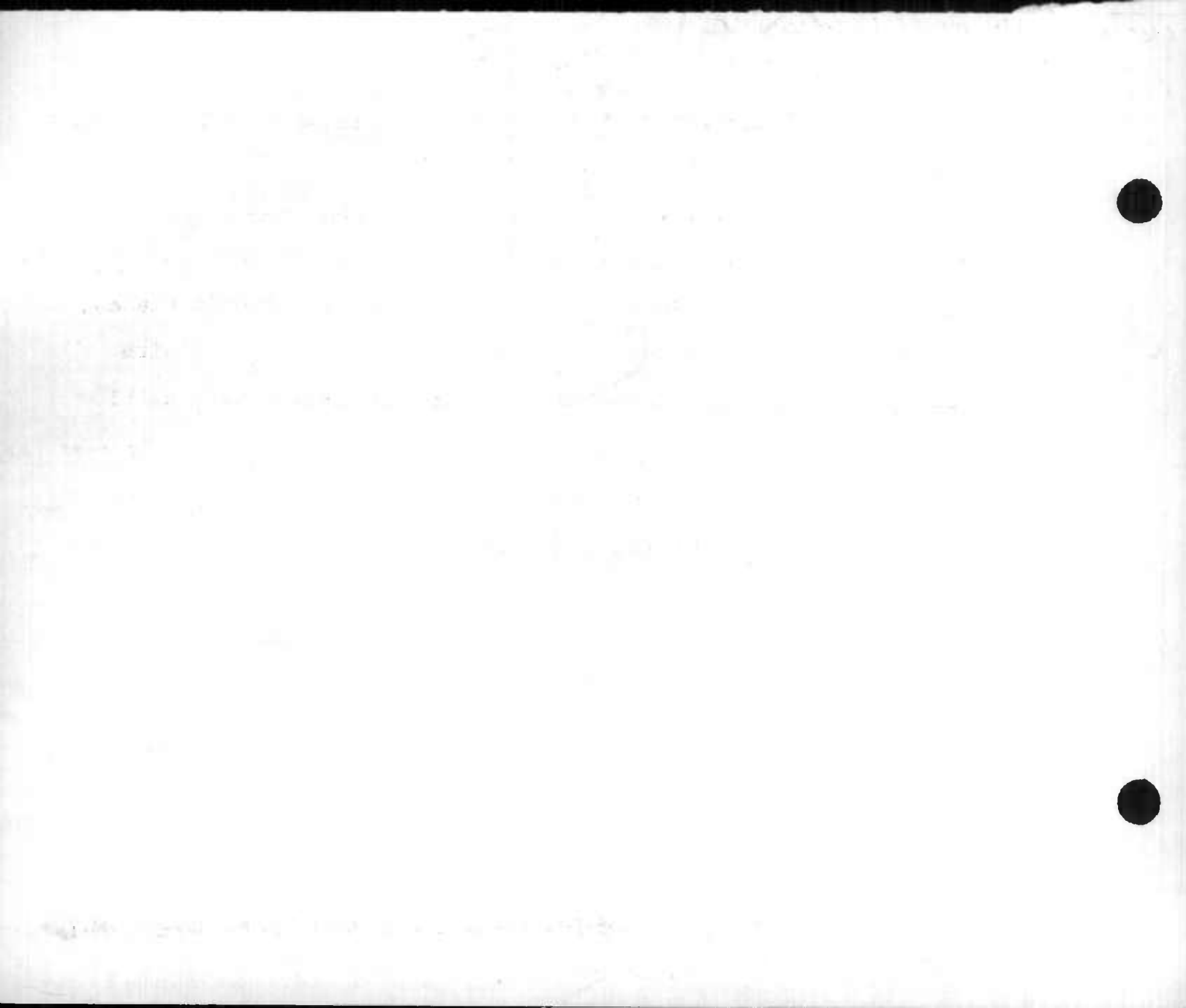
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/10/84	23c. NAME OF CEMETERY OR CREMATORY St John Mem Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Cold Spring Harbor N.Y.
24. FUNERAL DIRECTOR FLECK FUNERAL HOME INC. 7601 st Sandy Spring Rd. Laurel, Md.		25a. DATE REC'D. BY REGISTRAR OCT 9 1984	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified of cause.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					2 8 3 8 0				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roger C. HEYWOOD					2a. DATE OF DEATH MONTH DAY YEAR October 27, 1984				2b. HOUR 11:15pm
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR OCT. 9, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAMAICA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.			
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY HOWARD UNIV.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY PRINCE GEORGES GREENBELT		13c. CITY OR TOWN DOCTORS HOSPITAL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5811 CHERRYWOOD LA #301 20770	
14. FATHER'S NAME FIRST MIDDLE LAST DOUGLAS HEYWOOD					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOLA COX				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS DR. ROBIN R. COX 114 NEW EDGERLY RD, BOSTON, MASS. 02115					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Posthypoglycemic encephalitis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Diabetes</u> (c) <u>Diabetes</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Urinary tract infection</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-26</u> , 19 <u>84</u> , to <u>10-27</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10-26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Nirmala Khot Fernbach MD				DEGREE MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-28-1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NIRMALA KHOT FERNBACH				22e. ADDRESS 7726 Finns Lane LANHAM Md 20706.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10-30-1984		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md.		25. DATE REC'D. BY REGISTRAR'S SIGNATURE NOV 0 2 1984 John S. ...			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1 AND REMAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

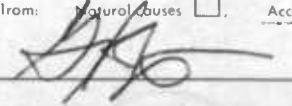

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(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Neta		MIDDLE C.		LAST Hidlebaugh		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/9/84 19		2b. HOUR 11:20 A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 8, 1909		6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/9/84 19		2d. HOUR A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY I.B.M.			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8501 Greenbelt Road 20770			
14. FATHER'S NAME FIRST MIDDLE LAST Hans Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ane Marie Hansen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 480-20-4665		17. INFORMANT ADDRESS 1203 N. Brandon Karen M. Shelton Ave. Sterling, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:15x 10/9/ 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject driver in auto/auto collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Intersection of Mandan & Greenbelt Rd. Greenbelt, Pr. Geo Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10/10/84			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Oct. 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 			

OCT 15 1984

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Machine Operator

Page 17

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2004-01-084

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 8 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE E HIGGS			2a. DATE OF DEATH MONTH DAY YEAR 10 15 84		2b. HOUR 5:57 PM		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 12 25 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. STATE Maryland		13b. COUNTY Pr. George		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2809 Sydney Ave. 20747							
14. FATHER'S NAME FIRST MIDDLE LAST Robert P. Wedding			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irella Frye				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-68-1284		17. INFORMANT ADDRESS Elmer R. Higgs 4407 Orlan La. Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Systolic Shock. DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic Mellitus. DUE TO, OR AS A CONSEQUENCE OF (c) Spontaneous. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (we) (the hospital) attended the deceased from 10/15 , 19 84 , to 10/15 , 19 84 , that (I) (we) lost saw the deceased alive on 10/15 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		22c. DEGREE [Signature]		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 10/16/84	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) G. P. WATKIN		22g. ADDRESS Waldorf, Md. 20681					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/19/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR OCT 17 1984			
				25b. REGISTRAR'S SIGNATURE J. Davidson-Randall			

BP

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Female	Grav.	15	25	10	13
Wash. D.C.	USA	X			
Robert	B.				
Wedding	Ireland				
Pr. George Townsville	X				
2809 Rodney Ave. 20717					
at home					
Housewife					

no

517-68-1281

Robert B. Place 1107 Orian Dr., Bowie, Md.

10/19/81

St. Olivet Cemetery

Washington, D.C.

O.P. Kals 6160 Oxon Hill Rd. Oxon Hill, Md.

OCT 17 1984

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Dr Rodriguez matched OK to

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 8 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel R. Hill			2a. DATE OF DEATH MONTH DAY YEAR 10 3 84			2b. HOUR 6:50 AM				
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 1 27 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. UNDER 1 YEAR MONTHS DAYS 1 1		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.				
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sign Writer		12b. KIND OF BUSINESS OR INDUSTRY Dept. Stores		
13a. STATE Maryland			13b. COUNTY Pr. George		13c. CITY OR TOWN Marlow Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3940 Bexley Pl. 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Padgett			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Hardestry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 579-26-8791		17. INFORMANT ADDRESS Kenneth Painter 5802 Lambert Dr. Temple Hills Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (b) EMPHYSEMA		YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTATIC BREAST CANCER			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10/2 19 84	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 10/2 , 19 84 , to 10/3 , 19 84 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 10/2 , 19 84 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.			
27b. SIGNATURE <i>[Signature]</i>		27c. DATE SIGNED 10/3/84	
27a. PHYSICIAN'S NAME (TYPE OR PRINT) Philip G. Wisotsky, M.D.		27e. ADDRESS 6188 Oxon Hill Rd. Oxon Hill, Md. 20745	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/6/84		23c. NAME OF CEMETERY OR CREMATORY Nat. Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Va.	
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR OCT 8 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

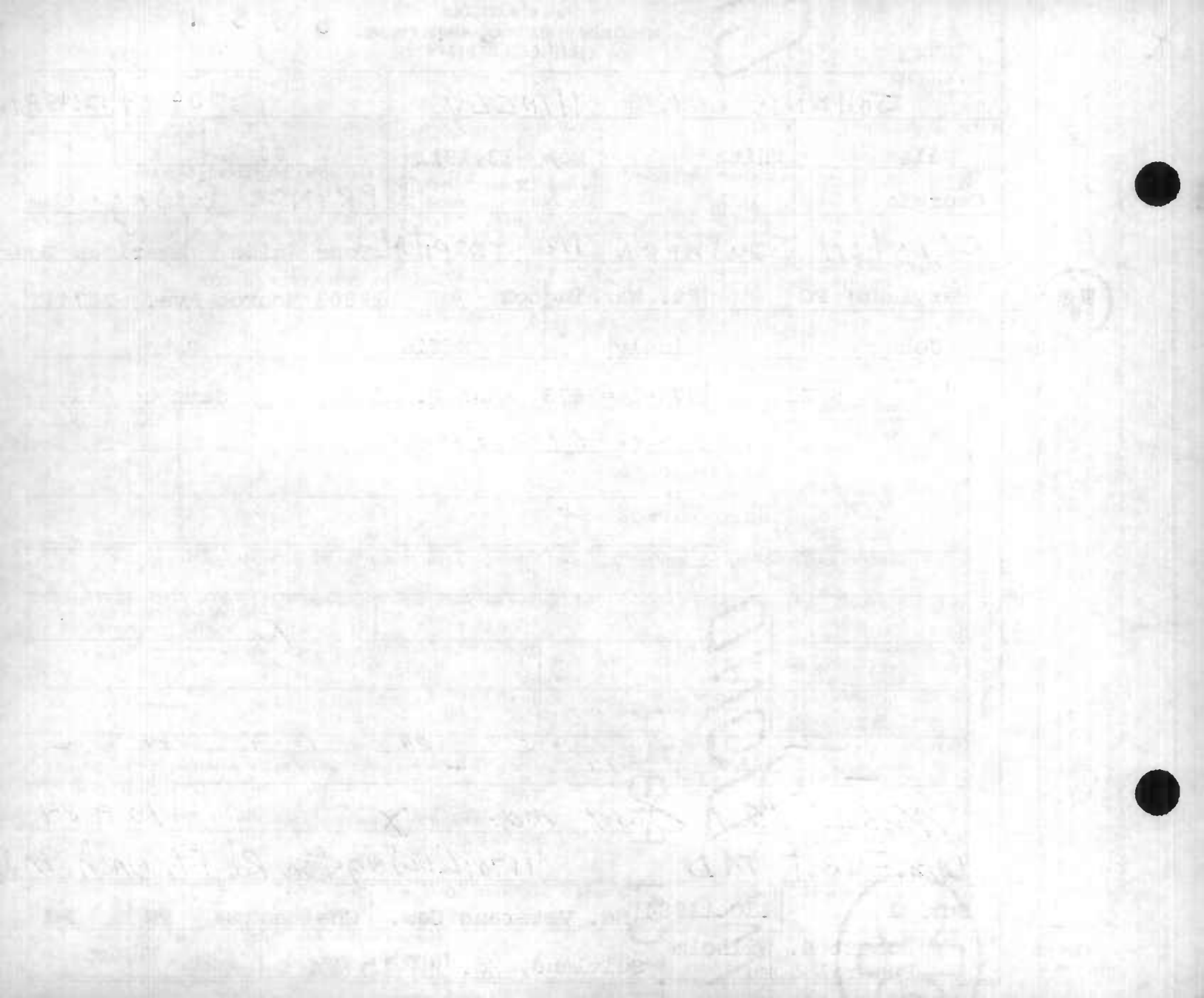
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		7a. DATE OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
JOHNNIE R HINELY		Male		White		Feb 13, 1911	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Georgia		USA				PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON		Southern Md Hospital		Tour Guide		American Tour	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE	
Maryland PG		Ft. Washington		NO		12803 Monroe Ave. 20744	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
John		Effie		Yes		WWII 578-10=5673	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Anna B. Hinely		Same as #13					
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				HOUR A.M. MONTH DAY YEAR	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
		WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 10-5, 1984, to 10-9, 1984, that (I) (we) lost saw the deceased alive on 10-8, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		William Kent Hunt MD		10 9 84		Wm. Furst MD	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		11 Oct 1984		Md. Veterans Cem.		Cheltenham PG Md	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME	
Robert E. Wilhelm		OCT 15 1984		Julia Davidson-Randall		Suitland, Md.	

BP



MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JAMES HODGE, Sr.					2a. DATE OF DEATH MONTH DAY YEAR 10 13 84 2b. HOUR 10:40 P M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Nat'l Cap. Housing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Landover					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7736 Bender Road 20785		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hodge					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Delaney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Florence Hodge (wife) same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontine Infarction DUE TO, OR AS A CONSEQUENCE OF: (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/13, 1984, to 10/13, 1984, that (I) (we) lost saw the deceased alive on 10/13, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George Orr M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE ORR, M.D.					22e. ADDRESS 6525 BELCREST RD., HYATTSVILLE, MD. 20782				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-18-84		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Vet. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden					25. DATE REC'D. BY REGISTRAR OCT 19 1984				
26. REGISTRAR'S SIGNATURE John Davidson-Randall									

10-11-1961

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

Re New York letter to Bureau dated 10/11/61.

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

44-38861-1001

ENCLOSURE

MM



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2b. HOUR			
FIRST MIDDLE LAST NELLE G HODGES				MONTH DAY YEAR 10 20 84			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Sept. 2, 1908		76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Kansas		U.S.A.				PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		PGG HOSPITAL AND MEDICAL CENTER		Principal		Elementary	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland P.G. Berwyn Hgts.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST James C. Glasgow				FIRST MIDDLE LAST Elizabeth D. Greathouse			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				511-14-5506		Address Same as No# 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Pancreatic Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 4-5 mos.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (b) (this hospital) attended the deceased from Sept 21, 19 84, to Oct 20, 19 84, that (I) (we) last saw the deceased alive on Oct 20, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Louis Y. Korman				DEGREE MD		22c. DATE SIGNED 10/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS Y. KORMAN				22e. ADDRESS 719 Northwest Dr SS MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Oct. 23, 1984		Fort Lincoln Cemetery		Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 23 1984 Julia Davidson-Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA L. HOLMES				10-19-84 2:45PM			
3. SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR March 18, 1944		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Government employee		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Suitland		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin H. Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jannie L. Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 56 8826		17. INFORMANT ADDRESS Lena Simmons-sister			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) extensive pleural, hepatic, & probable bony metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) this hospital attended the deceased from 9/30 19 84 to 10/19 19 84, that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death. Oct. 19 19 84							
22b. SIGNATURE Donna Rinis		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONNA RINIS M.D.		22e. ADDRESS GROUP HEALTH ASSOC., INC. 6525 BELCREST RD, HYATTSVILLE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24 FUNERAL DIRECTOR NAME Stewart		ADDRESS		25a. DATE REC'D BY REGISTRAR OCT 25 1984		25b. REGISTRAR'S SIGNATURE	

BP

EXHIBIT 100-100000

Oct 2 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELMER W. HOWER, Sr.					2a. DATE OF DEATH MONTH DAY YEAR HOUR 10 20 84 1:54AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 20, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH PLACE, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assistant Buyer		12b. KIND OF BUSINESS OR INDUSTRY Sears - Roebuck Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Brentwood		13e. STREET ADDRESS / ZIP CODE 4432 39th. Street 20722			
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Hower				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret M. Clem					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Army		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Peacetime		17. INFORMANT ADDRESS Mrs. Marian V. Hower		Address Same as No# 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOGENIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN 10 1975 to OCT 20 1984 that (I) (we) last saw the deceased alive on OCT 19 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David M. Goldman				DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Goldman, M.D.				22e. ADDRESS 6525 Belcrest Road - Hyattsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.				ADDRESS Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR 10/25/84		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez	

BP

NAME, ADDRESS, CITY, STATE, ZIP

Mr. J. B. Smith, 1234 Main St., Springfield, Ill. 62761

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nettie G. Hudson			2a. DATE OF DEATH MONTH DAY YEAR Oct. 5, 1984		2b. HOUR P. 12:05 M							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 27, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.						
10. CITY OR TOWN OF DEATH Upper Marlboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16401 Mt Calvert Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland				13b. COUNTY PG		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 16401 Mt Calvert Road 20772		
14. FATHER'S NAME FIRST MIDDLE LAST Matt Newsom				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Salley Evans								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No --				16b. SOCIAL SECURITY NO. 579-50-3877		17. INFORMANT Samuel C. Hudson				ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Collapse DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 11-26 , 19 82 , to 10-5 , 19 84 , that (I) (we) last saw the deceased alive on 10-3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b. SIGNATURE Thomas F. Cleary						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-9-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. Cleary						22e. ADDRESS 9131 Piscataway Rd. Clinton, Md 20735						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-8-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland				23d. LOCATION CITY OR TOWN COUNTY STATE PG Md		
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm						ADDRESS Suitland, Md		25a. DATE REC'D BY REGISTRAR OCT 10 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		
24. FUNERAL HOME Funeral Home												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

2. The second part of the document is a list of names and addresses, similar to the first part. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

3. The third part of the document is a list of names and addresses, similar to the first two parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

4. The fourth part of the document is a list of names and addresses, similar to the first three parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

5. The fifth part of the document is a list of names and addresses, similar to the first four parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

6. The sixth part of the document is a list of names and addresses, similar to the first five parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

7. The seventh part of the document is a list of names and addresses, similar to the first six parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

8. The eighth part of the document is a list of names and addresses, similar to the first seven parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

9. The ninth part of the document is a list of names and addresses, similar to the first eight parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

10. The tenth part of the document is a list of names and addresses, similar to the first nine parts. The names are written in a cursive hand, and the addresses are in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		8:25 A. M.							
Fred						Hutchinson		10/20		19		84				8:25 A. M.							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		10/20		19 84 A. M.							
Male	Black	Dec. 24, 1918		65 YRS.						10/20		19 84				8:25 A. M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																	
South Carolina		United States		Prince George's County MD																			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Landover		2447 Kent Village Place						Custodian/Alexandria &				Arlington, Va. School											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS															
Maryland		Prince George's		Landover		YES		2447 Kent Village Place/20785															
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)															
John D. Hutchinson				Estella Williams				Yes/Navy															
17a. SOCIAL SECURITY NO.				17b. INFORMANT				27 You Street, N. W.															
1943/1945				250-26-1626				Inez A. Jones (daughter) Wash. DC															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) _____																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
None																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				P.M. 19				None															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on																Autopsy <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion	
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				M.D.				TITLE (SPECIFY)				DATE SIGNED											
				M.D.				Deputy				10/20/84											
EXAMINER'S NAME (TYPE OR PRINT)				John S. Rogers, M.D.				ADDRESS				1919 Seminary Road Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				10/26/84				Harmony Memorial Park, Landover, P.G. Maryland															
24. FUNERAL DIRECTOR				LATNEY'S Funeral Home				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
3831 Ga. Ave. NW; Washington, DC 20011								JUL 20 1984															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					2. REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MINNIE B. JACKSON					2a. DATE OF DEATH MONTH DAY YEAR 10-15-84			2b. HOUR 6 00AM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5-6-18 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foster Grandparent Domestic		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.					13b. COUNTY P.G.		13c. CITY OR TOWN Fairmount Hts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter M. Chesney					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT Arthur Jackson Jr		ADDRESS 13 E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① BRONCHOGENIC CARCINOMA OF RIGHT LOBE AND METASTASIS. DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ① REFRACTORY HEART FAILURE. ② BONY METASTASIS.										
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA						
22a. I certify that (I) (this hospital) attended the deceased from 4-6-19 84, to 10/15/1984, that (I) (we) last saw the deceased alive on 10/13/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S Rudap MD				DEGREE MD				22c. DATE SIGNED 10/15/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHRINIVAS RUDAP				22e. ADDRESS 6005 LANDOVER RD CHEVERLY MD 20785						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-18-84		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem		23d. LOCATION CITY OR TOWN COUNTY STATE Landover P.G. Md				
24. FUNERAL DIRECTOR NAME H.S. Washington				ADDRESS 4925 Burroughs Ave NE		25a. DATE RECEIVED BY REGISTRAR 10/25/84				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 2 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 OR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 392	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Sarah Jackson										2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10-15 1984	
3 SEX FEMALE 4. RACE BLACK 5. DATE OF BIRTH MONTH DAY YEAR 4 - 10 - 1900 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. 7. CITIZEN OF WHAT COUNTRY? U. S. A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD 10-15 1984 2d. HOUR 3:10 a.m.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA 9b. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.											
10. CITY OR TOWN OF DEATH Fairmont Hgts. 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 907 Cyprus Tree Drive 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER 12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE MARYLAND 13b. COUNTY PRINCE GEO. 13c. CITY OR TOWN ADELPHI 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1810 METZEROTT, RD., 20783											
14. FATHER'S NAME FIRST MIDDLE LAST CUNDIFF UKN 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CRAIGHEAD CORDELIA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 130 20 3034 A 17. INFORMANT DAUGHTER ADDRESS BARBARA S. PULLAM SAME AS ABOVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke Inhalation 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 3+ 10-15 1984 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR subject recovered from house fire 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 907 Cyprus Tree Dr., Fairmont Hgts., Prince George's Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-15-84											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 10-20-84 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY 23d. LOCATION CITY OR TOWN COUNTY STATE clinton P.G. MD.											
24. FUNERAL DIRECTOR NAME JAMES T. SUTTON ADDRESS 5635 EADS ST. N.E. WASH.D.C. 25a. DATE REC'D. BY REGISTRAR OCT 18 1984 25b. REGISTRAR'S SIGNATURE J. Davidson											



MS 81 T30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate completed.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen G. Jacobs			2a. DATE OF DEATH MONTH DAY YEAR October 13, 1984		2b. HOUR 2 30 4M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 25, 1895		
6. AGE [IN YEARS LAST BIRTHDAY] 88 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home		13. STREET ADDRESS / ZIP CODE 6314-Inwood Street 20785		
14. FATHER'S NAME FIRST MIDDLE LAST Henry - Heinbuch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah - Moss		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)		
16b. SOCIAL SECURITY NO. 578-62-4920		17. INFORMANT ADDRESS Margaret M. Wilson (Daughter) Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no		
19a. DATE OF OPERATION 2/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 7/18 , 19 80 , to 10/13 , 19 84 , that (I) (we) lost saw the deceased alive on 10/3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death						
22a. SIGNATURE Don B. Cameron		DEGREE MD		22c. DATE SIGNED Oct. 15, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don B. Cameron, MD, PA		22e. ADDRESS 6490-Landover Road, Cheverly, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 15, 1984		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		24. FUNERAL DIRECTOR NAME ADDRESS J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002				
25a. DATE REC'D. BY REGISTRAR OCT 17 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 9 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST DELORES	MIDDLE M	LAST JOHNSON	2a. DATE OF DEATH		MONTH 10	DAY 1	YEAR 84	2b. HOUR 10:47 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Private			
13a. STATE Maryland					13b. COUNTY Prince Geo.		13c. CITY OR TOWN Accokeek		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Lucas					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-42-8182		17. INFORMANT ADDRESS John C. Johnson Accokeek, Maryland 20607					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>hemorrhage following mesocystitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hepatic cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic ethanol abuse</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>many years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>thrombocytopenia, esophageal varices, anemia</u>											
19a. DATE OF OPERATION <u>9/25/84</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>bleeding esophageal varices</u>				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>84</u> , to <u>10/1</u> , 19 <u>84</u> , that (b) (we) last saw the deceased alive on <u>10/1/84</u> , 19 <u>84</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ronald Landman MD</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/2/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ronald Landman MD</u>				22e. ADDRESS <u>9440 Pennsylvania Ave Upper Marlboro</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-4-84		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION CITY OR TOWN COUNTY STATE Piscataway P.G. Md.					
24. FUNERAL DIRECTOR NAME Thornton Funeral Home						ADDRESS Pomonkey, Md.		25a. DATE REC'D. BY REGISTRAR <u>OCT 5 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET
NO FORN DISSEM
NO UNCLASSIFIED

1. The purpose of this document is to provide information regarding the status of the project and the progress of the work. The information is intended for the use of the project manager and the project team.

2. The project is currently in the planning phase. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

3. The project is expected to be completed by the end of the year. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

4. The project is currently in the planning phase. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

5. The project is expected to be completed by the end of the year. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 3 9 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis Joseph JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR October 5, 1984			2b. HOUR 9:25P M				
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 22, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hosp. of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harold Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Gartner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Elsie M. Johnson (Wife)			ADDRESS Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) severe peripheral vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) liver and renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION 9/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal aortic aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 9/4 19 84 to 10/5 19 84 , that (1) (we) last saw the deceased alive on 10/5 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bruce M. Lowman			DEGREE MD. ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-6-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE LOWMAN			22e. ADDRESS 5901 MEDICAL TERRACE, CHEVERLY							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-9-84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.					25a. DATE REC'D. BY REGISTRAR OCT 11 1984					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

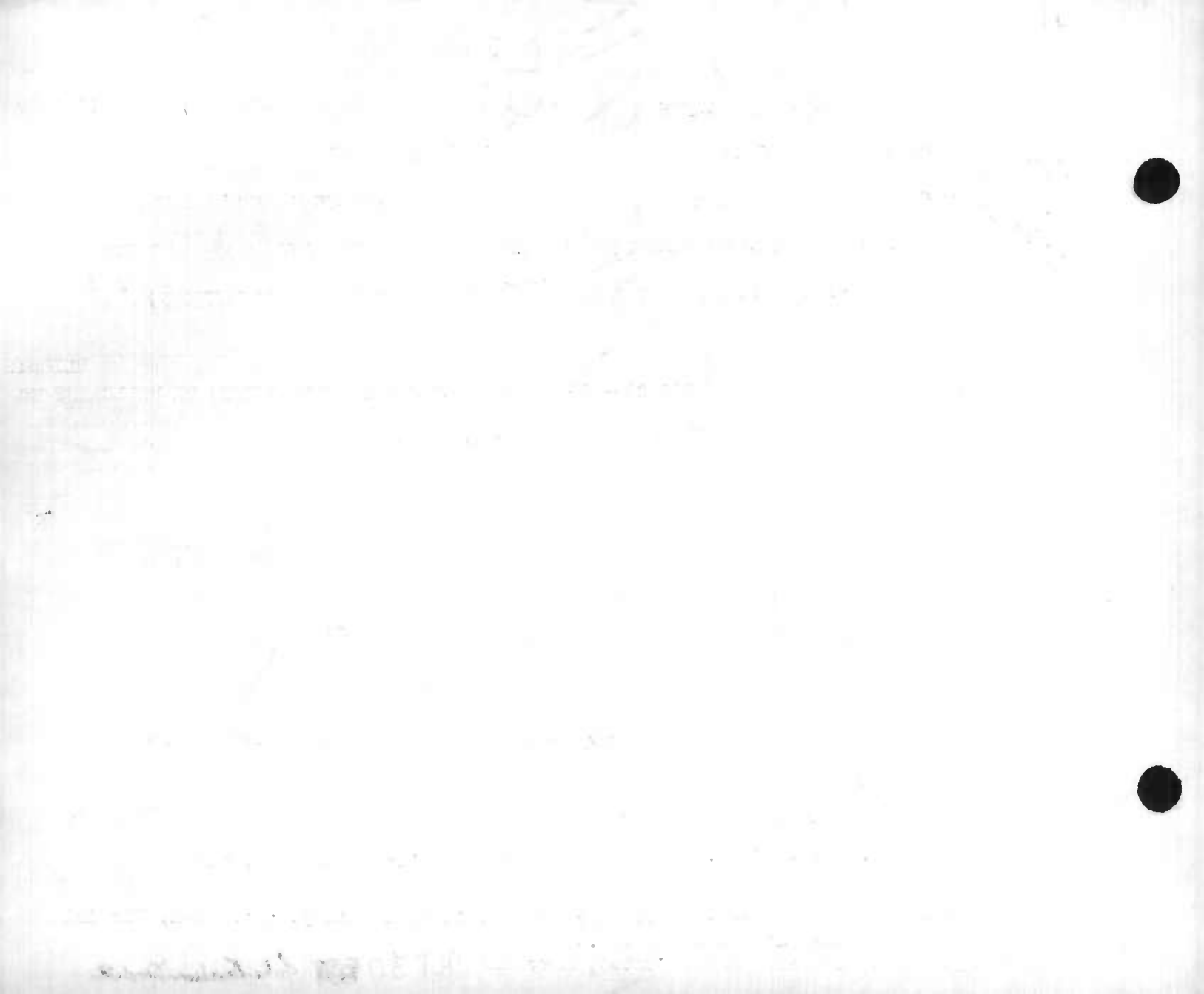
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called out on duty.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST ROBERT AARON JOHNSON				OCT 27, 1984				11 12PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JULY 31 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MED CEN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US NAVY		12b. KIND OF BUSINESS OR INDUSTRY MILITARY			
13a. STATE MD				13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN HILLCREST		13d. STREET ADDRESS / ZIP CODE 3340 CURTIS DRIVE 20031	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 253-24-9473		17. INFORMANT ADDRESS LENORA JOHNSON 3340 CURTIS DR HILLCREST MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>228 27 OCT 84</u> , 19 <u>84</u> , to <u>234 27 OCT 84</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE <u>John H. Wales, M. D.</u> DEGREE	
22c. DATE SIGNED <u>28 OCT 84</u>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Wales, M. D.		22e. ADDRESS Andrews Air Force Base, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE November 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>John H. Wales, M. D.</u>					

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DONALD H. JONES						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10-31-84		2b. HOUR M			
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR Jan. 14 1933	6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 11-5-84		2d. HOUR 11:25 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Fort Washington		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11402 Indian Head Hgwy.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Mitre Corp. 20745			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY OR TOWN Prince George's Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1809 Owens Road					
14. FATHER'S NAME FIRST MIDDLE LAST George Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Daniels							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean		16b. SOCIAL SECURITY NO. 283-28-4552		17. INFORMANT Ada M. Jones ADDRESS 1809 Owens Road Oxon Hill, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of neck DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? ? ? 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject found shot						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hgwy.		21f. LOCATION 11402 Indian Head Hgwy. Fort Washington, Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER		DATE SIGNED 11-5-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/9/84		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home Oxon Hill, Md.					25a. DATE REC'D. BY REGISTRAR NOV 9 1984		25b. REGISTRAR'S SIGNATURE <i>Ala. Burdon-Randall</i>				

MEDICAL CERTIFICATION

Male Negro Jan. 11 1933 51

Ohio U.S.A.

Engineer

1809 Owen Road

George's Owen Hill

Jones

George

583-28-1222

Korean

Yes

Ada M. Jones

1809 Owen Road
Owen Hill, Maryland

Louisiana

George L. Jones, Maryland, Owen Hill, Md.
Maryland, Veterans Com.
Owen Hill, Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Irene			FIRST MIDDLE LAST JONES			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10-9-84			2b. HOUR M 1205				
3. SEX Female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 10-6-42		6. AGE (IN YEARS) (LAST BIRTHDAY) 42 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-10-84			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH Oxon Hill			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1445 Southern Avenue, P3						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Assistant		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland			13b. COUNTY Oxon Hill			13c. CITY OR TOWN Oxon Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1445 Southern Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Williams						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Mae Ellis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 425 70 7438				17. INFORMANT ADDRESS 1445 Southern Avenue Milton Jones-husband					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast, metastatic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				DATE SIGNED 10-10-84					
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 15, 1984			23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Lanodver, Md.				
24. FUNERAL DIRECTOR'S NAME Stewart						25a. DATE REC'D. BY REGISTRAR OCT 11 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

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23. on 10-10-15

and can be used for

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Item #6-3598-12/20/84 JP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 28399
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Patricia Dowell Jones</i>		2a DATE KNOWN OF DEATH <i>Oct 13 1984</i>		2b HOUR <i>1130 P M</i>
3 SEX <i>F</i>	4 RACE <i>Blk</i>	5 DATE OF BIRTH <i>Nov 12 1943</i>	6 AGE <i>40</i> YEARS	7 IF UNDER 1 YR. MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>DENVER COLORADO</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10 CITY OR TOWN OF DEATH <i>Hyattsville</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>66th Ave</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>NONE</i>
13a STATE <i>MARYLAND</i>		13b COUNTY <i>PRINCE GEORGES</i>		13c CITY OR TOWN <i>HYATTSVILLE</i>
14 FATHER'S NAME <i>THEODORE JONES</i>		15 MOTHER'S MAIDEN NAME <i>ESTER JONES ROBINSON</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>
16b SOCIAL SECURITY NO. <i>UNK</i>		17 INFORMANT <i>BEVERLY JONES</i>		18 ADDRESS <i>4842 66TH AVE HYATTSVILLE</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Sickle Cell Anemia</i> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>				
19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John P. Rogers</i>		TITLE (SPECIFY) <i>M.D.</i>		DATE SIGNED <i>Oct 14 1984</i>
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b DATE <i>10/19/84</i>	23c NAME OF CEMETERY OR CREMATORY <i>HARMONY MEMORIAL</i>	23d LOCATION CITY OR TOWN <i>LANDOVER</i>	23e COUNTY <i>P.G. MARYLAND</i>
24 FUNERAL DIRECTOR NAME <i>J.B. JENKINS</i>		ADDRESS <i>FUNERAL HOME 7474 LANDOVER RD</i>		25a DATE REC'D. BY REGISTRAR <i>OCT 15 1984</i>
		25b REGISTRAR'S SIGNATURE <i>Lila Davidson-Rodale</i>		

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN A COPY OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



Oct 19 1945

Mr. J. H. ...

Handwritten text, possibly a signature or name.

Handwritten text, possibly a signature or name.

Handwritten text, possibly a signature or name.



OCT 15 1945

Dr Rodriguez notified. Release to Mrs.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		10 07 84		2:10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		Dec. 20, 1912		71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Wash., D.C.		U.S.A.				PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON		Southern Md Hospital		Retired-GPO			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE	
Maryland		Temple Hills		YES <input type="checkbox"/> NO <input type="checkbox"/>		6413 Gifford Lane 20748	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
Linus Joy		Anna Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		679 01 4087		3101 Crafford Drive-Fort Wash., Md. Mrs. Constance Smith-daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)		3 YEARS			
		DUE TO, OR AS A CONSEQUENCE OF (c)		3 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 19 84, that (I) (we) last saw the deceased alive on Oct 5 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		Terence Bertele MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		10/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
TERENCE BERTELE		7501 SURREATS RD CLINTON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		OCT 21 1984		Gate of Heaven Cemetery		CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME	
Stewart Funeral Home-4001 Benning Road, NE		OCT 11 1984		John Davidson		M.D.	

Mr. J. Edgar Hoover

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

28401

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST CHARLIE JOYNER			MONTH DAY YEAR 10/18/84			6:02 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	BLACK	MONTH DAY YEAR 9-12-28		56 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
NORTH CAROLINA	U.S.			Prince Georges County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
JESSUP	Greater Laurel Beltsville Hospital			COOK				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS - ZIP CODE				
MARYLAND	Prince Georges	JESSUP	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7412 FRANKLIN DRIVE 20794				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
ROBERT JOYNER			MARY ANDERSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
				CHART				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): DIABETES MELLITUS BILATERAL CAROTID STENOSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
				Ave 82, to 10, 84				
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE R. E. S. M. A. L. H. A. D. O.				DEGREE MD		22c. DATE SIGNED 10/18/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESMALHADO				22e. ADDRESS 321 PRINCE GEORGE ST.				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL		10/2/84		MARYLAND NAT.		Laurel MARYLAND		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
E. L. Phillips				1721-21 N. MONROE		OCT 22 1984		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Amy Virginia Kaiser			2a DATE OF DEATH MONTH DAY YEAR October 06, 1984			2b HOUR 11:26 P _M			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR June 15 1914		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10 CITY OR TOWN OF DEATH Laurel		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY ---	
13a STATE Maryland					13b COUNTY Howard		13c CITY OR TOWN Laurel		
14 FATHER'S NAME FIRST MIDDLE LAST Millard --- Murphy			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST mary --- Dustin						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No N/A			16b SOCIAL SECURITY NO. 214-20-8018		17 INFORMANT ADDRESS Donald B. Kaiser Same as #13e				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiovascular Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardiovascular Shock

DUE TO, OR AS A CONSEQUENCE OF

(c) Severe Coronary Artery Disease

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Congestive Heart Failure

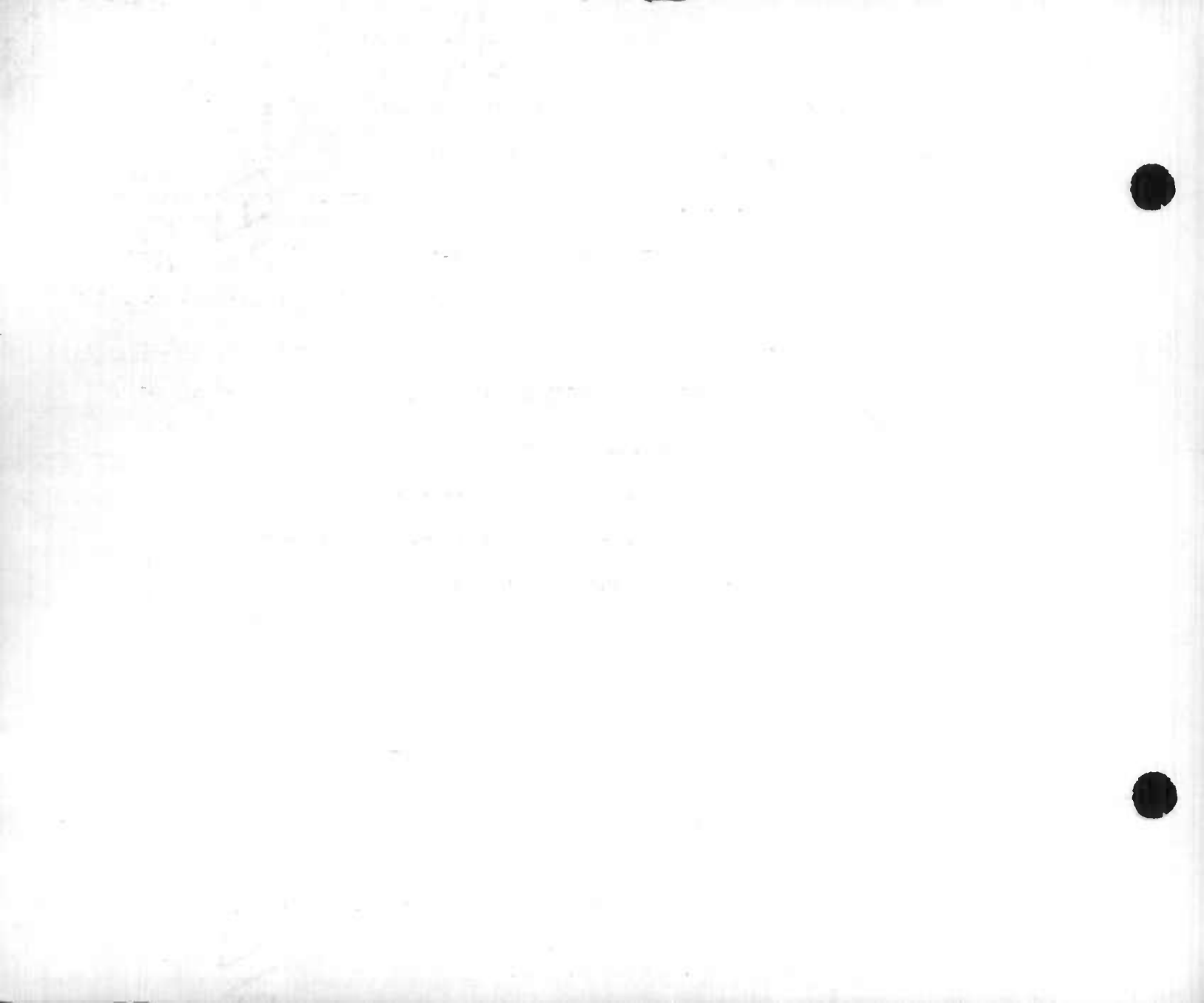
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10-6-1984 to 10-6-1984, that (I) (we) last saw the deceased alive on 10-6-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE C. Delmon				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-7-84	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/9/84		23c NAME OF CEMETERY OR CREMATORY Emanuel Cemetery		23d LOCATION Scaggsville, Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS FLECK FUNERAL HOME INC. 7601 Sandy Spring Rd. Laurel, Md.				25a DATE REC'D. BY REGISTRAR OCT 9 1984		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

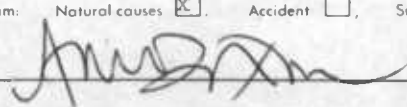

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																					
1. DECEASED NAME (TYPE OR PRINT) JACK Frank KATZ										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 10 DAY 11 YEAR 84		7b. HOUR 7:52									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH June DAY 14 YEAR 1950		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 10 11 84		7d. HOUR 7:52							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County									
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder				12b. KIND OF BUSINESS OR INDUSTRY HRW Systems									
13a. STATE Maryland										13b. CITY OR TOWN P.G.		13c. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 6902 Farragut Street 20784							
14. FATHER'S NAME FIRST John MIDDLE Abraham LAST Katz										15. MOTHER'S MAIDEN NAME FIRST Billie MIDDLE Lucille LAST Walter											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes--				16b. SOCIAL SECURITY NO. 220-54-1203				17. INFORMANT Mrs. Elizabeth K. Katz				17b. ADDRESS Address Same as No# 13c.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism <div style="display: flex; align-items: center;"> <div style="border-left: 1px solid black; padding-left: 10px; margin-right: 10px;"> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. </div> <div> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ </div> </div>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 10-12-84									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Oct. 15, 1984				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory				23d. LOCATION CITY OR TOWN Brentwood COUNTY P.G. STATE Maryland									
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. ADDRESS Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 15 1984				25b. REGISTRAR'S SIGNATURE 													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) Howard Joseph Keim					2a DATE OF DEATH MONTH DAY YEAR October 26, 1984			2b HOUR 7:00PM		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 19, 1930		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.				
10 CITY OR TOWN OF DEATH Andrews Air Force Base		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow U.S.A.F. Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Letter Carrier		12b KIND OF BUSINESS OR INDUSTRY Service		
13a STATE Maryland					13b COUNTY Prince George's		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS 12005 Marvel Lane (20715)										
14 FATHER'S NAME FIRST MIDDLE LAST Herman A. Keim					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Muench					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) Korea/Viet Nam 051-24-2435		17 INFORMANT ADDRESS Esta Ruth Keim - Same As #13 A-E			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Oat Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to <u>26 Oct</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Martin A. De Francesco, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED 10/27/81				
22d PHYSICIAN'S NAME (TYPE OR PRINT) Martin A. De Francesco, M. D.						22e ADDRESS Andrews Air Force Base, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE October 31, 1984		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24 FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. Old Alexander Ferry Road, Clinton, Maryland						25a DATE REC'D. BY REGISTRAR OCT 30 1984		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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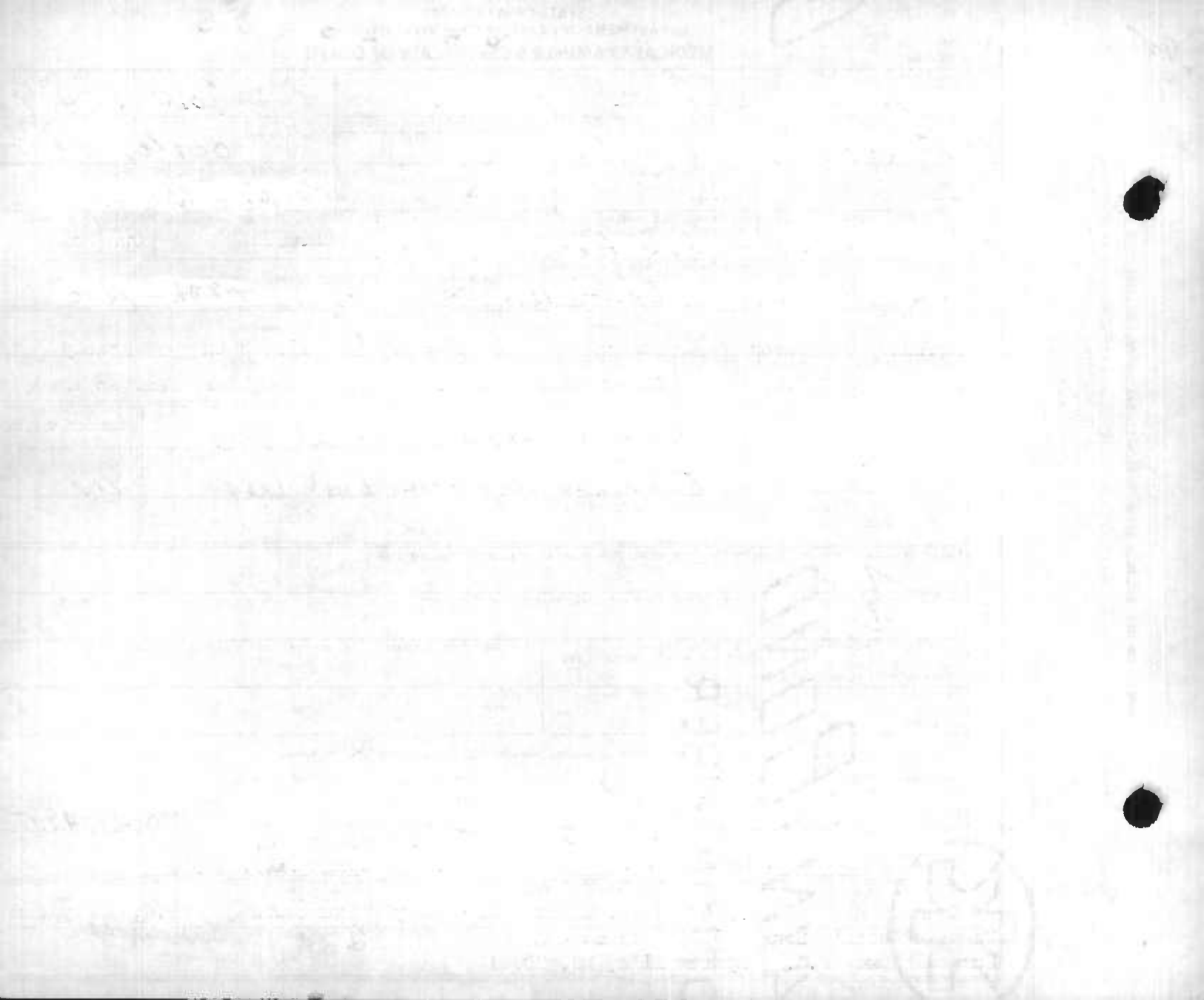
Handwritten text, possibly a signature or name, appearing in the center of the page.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Elizabeth Kelly										2a. DATE KNOWN OF DEATH MONTH DAY YEAR HOUR MIN OCT 16 19 43 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 19 21		6. AGE (IN YEARS) LAST BIRTHDAY 63		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR MIN OCT 16 19 43 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Riverdale				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9517 49th Avenue 20740			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Jason Baston						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eddeana Elizabeth Greely					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT ADDRESS Joanne Leizear (Daughter) Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.						TITLE (SPECIFY) 1910 Seminary Rd.			DATE SIGNED OCT 17 1984		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers M.D.						ADDRESS Silver Spring, Md. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 10/19/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. NAME OF FUNERAL HOME Francis Casch's Sons						24b. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781			25. DATE RECEIVED BY REGISTRAR OCT 23 1984		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

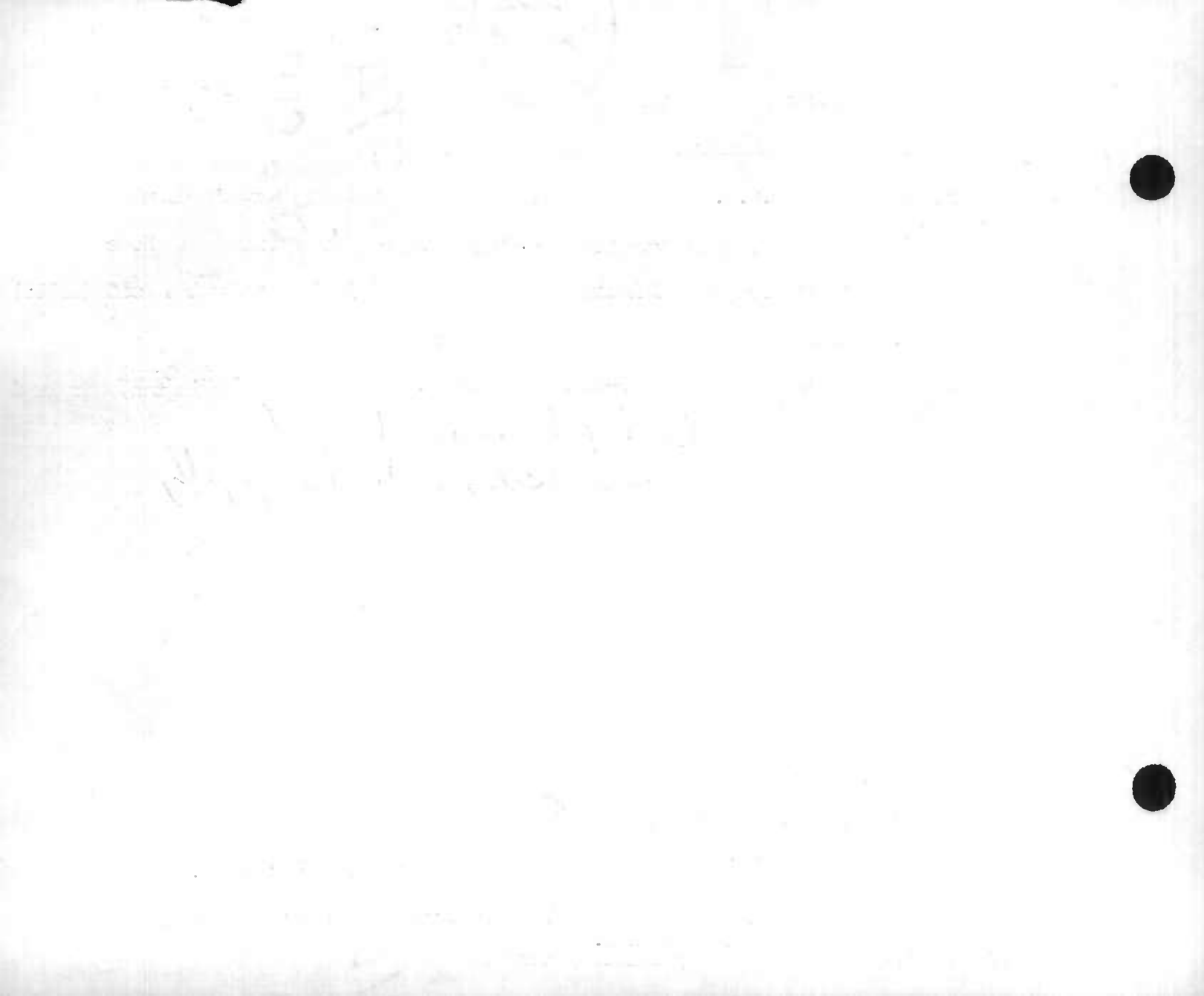
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leona Mae Kerns			2a. DATE OF DEATH MONTH DAY YEAR 10-02-84		2b. HOUR 6:45A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 23, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.	
10. CITY OR TOWN OF DEATH CLINTON, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince George's	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry C. Bodine			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Ramsey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Sandra L. Burnett 9403 Dania Court Fort Washington, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Severe Ischemic Cardiomyopathy</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John Patterson</i> DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN PATTERSON, M.D.				22e. ADDRESS 7501 SURRATTS RD. CLINTON, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 4, 1984	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg, Virginia
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR OCT 15 1984		
25b. REGISTRAR'S SIGNATURE NAME 16633 Old Alexander Ferry Road, Clinton, Maryland			25c. REGISTRAR'S SIGNATURE <i>John Patterson</i>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGES 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 407	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) BESS I KING										2a. DATE KNOWN OF DEATH MONTH 10 DAY 01 YEAR 1984	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 16 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD MONTH 10 DAY 01 YEAR 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Suitland MD				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. CITY OR TOWN PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20735 3417 Forestville Place			
14. FATHER'S NAME FIRST Stephen MIDDLE O. LAST Haselden						15. MOTHER'S MAIDEN NAME FIRST Rosa MIDDLE . LAST Marlow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-01-6614		17. INFORMANT ADDRESS Harry J. King, Same as 13 E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thromboembolism DUE TO, OR AS A CONSEQUENCE OF (b) left hip fracture DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 6 MONTH 9 DAY 08 YEAR 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell in yard					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) at home		21i. LOCATION STREET 3417 Forestville Place CITY OR TOWN Forestville COUNTY P.Gep. STATE MD					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Augusto P. Rodriguez						TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 10/1/1984	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.						ADDRESS 5009 Rayburn Ct., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-04-84		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		23d. LOCATION CITY OR TOWN Suitland COUNTY PG STATE MD			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm ADDRESS 4308 Suitland Rd						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John K. ...			
Funeral Home Suitland MD						OCT 10 1984					

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520 FINE AND FINE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE E. KING			2a. DATE OF DEATH MONTH DAY YEAR 10/27/84		2b. HOUR pm 12:05 am			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR FEB 18, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Washington DC		13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIMITS? NO		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Kuhnert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Saddler		13e. STREET ADDRESS / ZIP CODE 1800 Branch Avenue S.E. 20020				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Audrey Sullivan Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last (c) Cardiopulmonary Arrest Severe Congestive Heart Failure & Pulmonary Edema Aortic Insuff. & Mitral Regurgitation PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe, acute Compression Fractures T10 - T12 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:40/8 84 10/27 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN) COUNTY STATE Clinton Prince George's County Va				
22a. I certify that (I) (this hospital) attended the deceased from 8/40/8 84 to 10/27 84 , that (I) (we) lost saw the deceased alive on 10/26 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated 22b. SIGNATURE Dr. Jack Hudson M.D. 22c. DATE SIGNED 10/27/84 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HUDSON 22e. ADDRESS 9015 Woodburn Rd Clinton Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/84		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (CITY OR TOWN) COUNTY STATE Arlington Prince George's County Va		
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm ADDRESS Funeral Home Suitland, Md				25. DATE REC'D. BY REGISTRAR 10/27/84 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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THE UNIVERSITY OF CHICAGO
LIBRARY

Formal in form
and in style

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There is a great deal of
information to be
gathered from the
study of the
history of the
people of the
world.

It is a very interesting
subject and one which
should be studied by
all who are interested
in the history of the
world.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EVERETT William KNOLL						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 10 DAY 21 YEAR 84		2b. HOUR 19		2c. DATE PRONOUNCED DEAD 10 21 1984	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 10 YEAR 20		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YR. MONTHS 0 DAYS 0		7. IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES				10. CITY OR TOWN OF DEATH DISTRICT HGTS				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6706 Foster Street			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Micro Biologist				12b. KIND OF BUSINESS OR INDUSTRY US GOVET.				13. STREET ADDRESS 6706 Foster Street			
13a. STATE MD				13b. COUNTY PG		13c. CITY OR TOWN District Hgts		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 6706 Foster Street	
14. FATHER'S NAME FIRST Arthur MIDDLE Knoll LAST Knoll						15. MOTHER'S MAIDEN NAME FIRST Verna MIDDLE Fisher LAST Fisher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 477-12-3582		17. INFORMANT Marjorie Knoll				ADDRESS Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) Deputy				DATE 10/21/1984			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Court, Temple Hills, Md.				DATE 10/21/1984			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 10/22/84		23c. NAME OF CEMETERY OR CREMATORY cedar Hill Crematory				23d. LOCATION CITY OR TOWN SUITLAND COUNTY PG STATE MD	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm ADDRESS Funeral Home				25a. DATE REC'D BY REGISTRAR 10/30/84				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 1 0

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Alma Cecelia Knott		September 19, 1984		5:55 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		12 28 1891		92 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.				Prince George's County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville		Sacred Heart Home		Money Examiner		Bureau of Eng.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
N/A		N/A		Washington DC		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Benjamin Frank Knott		Ann Underwood		No		576-60-2055	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mary F. Loskill (Niece) Greenbelt, Md. 20770		9166 Edmondston Rd.		(a) Arteriosclerotic Heart Disease		10 years	
				(b) Hypertension, Aortic Aneurysm			
				(c) Anemia			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/15/84 19 80 to 9/1/84 19 84, that (I) (we) lost the deceased alive on 9/1/84 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Ibrahim M. Khatri, M.D.						10/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
				6525 Belcrest Rd., Hyattsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		9/22/84		Cedar Hill Cemetery		Suitland P.G. Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons		OCT 16 1984		Julia Davidson-Randall			
Funeral Home P.A.		Hyattsville, Md. 20781					

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION



Information for the Bureau
Investigation, North American
Division

FROM: Bureau of Investigation, Washington, D.C.

TO: Director, FBI

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) KEVIN James KNOX										2a. DATE KNOWN OF DEATH MONTH 10 DAY 12 YEAR 84		2b. HOUR M 19	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH Feb. DAY 6, YEAR 1970		6. AGE (IN YEARS) LAST BIRTHDAY 14 YRS.		7c. DATE PRONOUNCED DEAD MONTH 10 DAY 12 YEAR 84		2d. HOUR P 2:00 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD			
10. CITY OR TOWN OF DEATH Cheverly, Md.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Cap. Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 700 Clovis Ave. 20743			
14. FATHER'S NAME FIRST James MIDDLE James LAST Knox Jr.						15. MOTHER'S MAIDEN NAME FIRST Patricia MIDDLE Ann LAST Quarles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Patricia A. Knox 700 Clovis Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8122 IMMEDIATE CAUSE (a) MULTIPLE INJURIES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) 7 DUE TO, OR AS A CONSEQUENCE OF (c) 7										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION 10/6/1984				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? injuries						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 5:54pm MONTH 10 DAY 06 YEAR 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) operator of minibike which ran into van							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION CITY OR TOWN Capitol Hgts, PR, Md STREET intersection of Elfin Ave. & Fable St. COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Augusto P. Rodriguez M.D.						TITLE (SPECIFY) Deputy			DATE SIGNED 10/13/1984				
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.						ADDRESS 5009 Rayburn Ct., Temple Hills, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-19-84		23c. NAME OF CEMETERY OR CREMATORY Harmony memorial L Andover, m P.G. md.				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Comer-Hodges ADDRESS 4901 MARL. PIKE Hillside Md						25a. DATE REC'D. BY REGISTRAR OCT 25 1984		25b. REGISTRAR SIGNATURE John B. ...					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED; WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (LAST, FIRST, MIDDLE) FRANCIS Frank Joseph Kopitsch			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> Oct 24 1984		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> Aug 19 1927	6. AGE (IN YEARS) LAST (BIRTHDAY) MONTHS DAYS HOURS MIN. 57	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> Oct 24 1984
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZENSHIP USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Baltimore Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ANALYST	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY Prince Georges 13d. CITY OR TOWN Laurel		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS 200 FT MEADE RD 20707	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK N. KOPITSCH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA SCHAUPF		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 078-20-9507		17. INFORMANT ADDRESS SAME AS DECEASED	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Rogers		TITLE (SPECIFY) M.D.		DATE SIGNED Oct 24 1984	
EXAMINER'S NAME (TYPE OR PRINT) JOHN ROGERS		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT 27 1984		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
23d. LOCATION CITY OR TOWN SILVER SPRING		COUNTY MD		STATE	
24. FUNERAL DIRECTOR NAME DONALDSON FUNERAL HOME		ADDRESS LAUREL MD		25a. DATE REC'D BY REGISTRAR OCT 29 1984	
25b. REGISTRAR'S SIGNATURE John Rogers					

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1. 1971

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10. 1980

11. 1981

12. 1982

13. 1983

14. 1984

15. 1985

16. 1986

17. 1987

18. 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Marguerite Emma Kretschmer			2a. DATE OF DEATH MONTH DAY YEAR October 30 1984		2b. HOUR 6¹⁵ PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 3 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assistant		12b. KIND OF BUSINESS OR INDUSTRY Plastic Surgeon	
13a. STATE Maryland		13b. COUNTY Pr George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3912 York Lane 20715		14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Kretschmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Werner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 051-14-1677		17. INFORMANT Mr. Kim FitzGerald		17a. ADDRESS 3912 York Lane Bowie, Maryland 20715			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart attack DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min-1 hr mm 4 1/2 mm 1 hour
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Nephrolithiasis**

19a. DATE OF OPERATION 9/25/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED L. Wilhelms. M. M. M.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/9 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/9 1984 to 10/30 1984 , that (I) (we) last saw the deceased alive on 10/30 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Frederick H. Wilhelm, M.D.		22c. DATE SIGNED 10/31/84		22d. ADDRESS 5507 Annapolis Road, Hyattsville, MD			

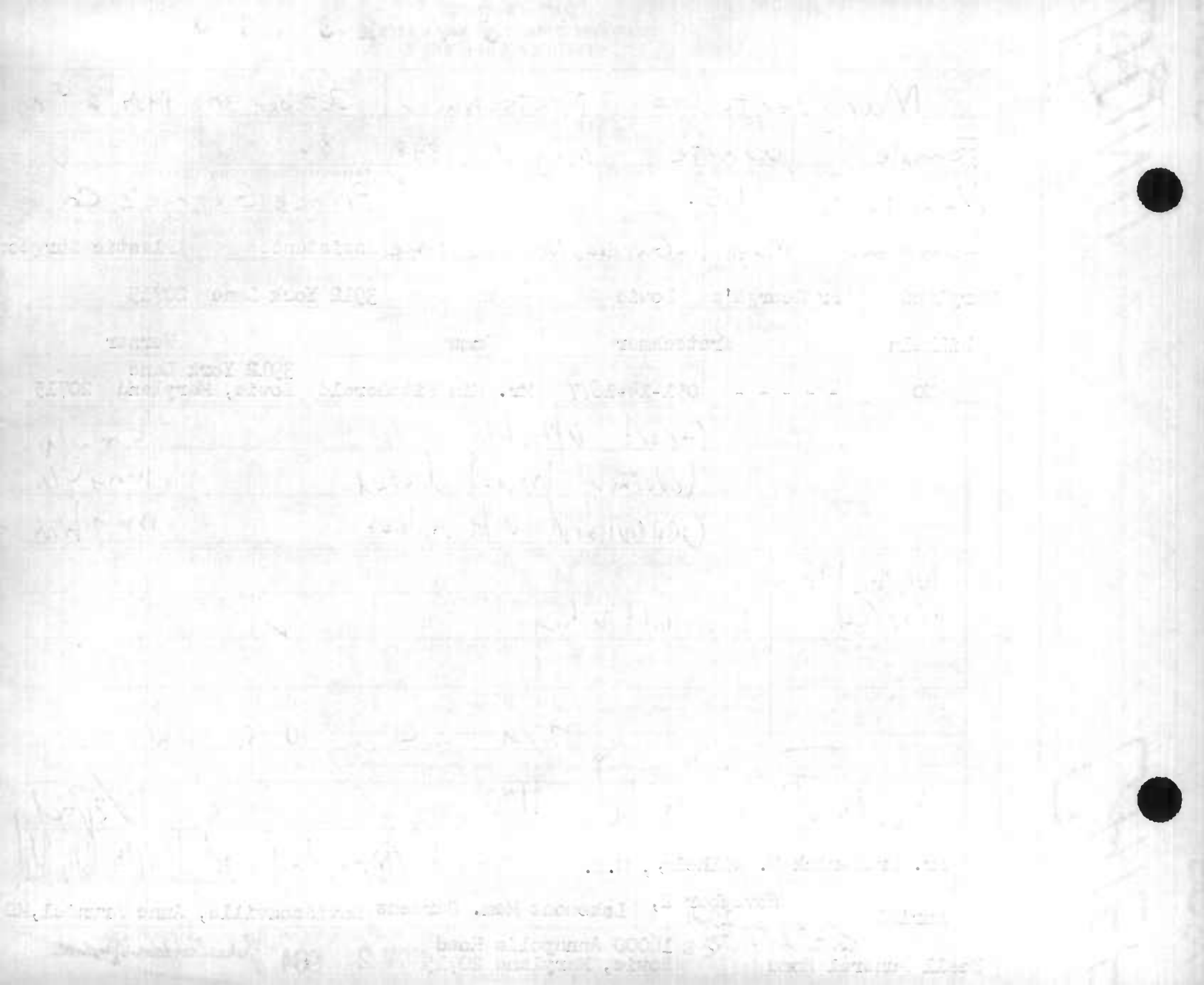
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE November 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, Anne Arundel, MD	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		24a. ADDRESS 16000 Annapolis Road Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR NOV 2 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


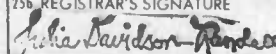
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAMES EDWARD KUPPERIAN, Jr.										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR OCT. 7 1984	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR APRIL 17 25 59 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 59 YRS.		7c. DATE PRONOUNCED DEAD OCT. 7 1984		7b. HOUR 12:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin				7b. CITIZEN OF WHAT COUNTRY? USA				9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH BOWIE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BOWIE HEALTH CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist		12b. KIND OF BUSINESS OR INDUSTRY NASA	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE M.D.		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 2702 LYN PLACE 20715			
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Kupperian, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Virginia Hoiland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS 12201 Foxhill Lane Joseph A. Berkowitz Bowie, MD 20715					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC MYOCARDIAL DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). NONE											
19a. DATE OF OPERATION NONE				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. DEP.		MEDICAL EXAMINER		DATE SIGNED OCT. 7, 1984	
EXAMINER'S NAME (TYPE OR PRINT) Dr. John S. Rogers, M. D.						ADDRESS 1919 Seminary Road Sil.Sprg., MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-10-84		23c. NAME OF CEMETERY OR CREMATORY Gracelawn Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE New Castle, New Castle, Delaware	
24. FUNERAL DIRECTOR NAME Beall Funeral Home ADDRESS 16000 Annapolis Road Bowie, MD 20715						25a. DATE REC'D. BY REGISTRAR OCT 9 1984		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

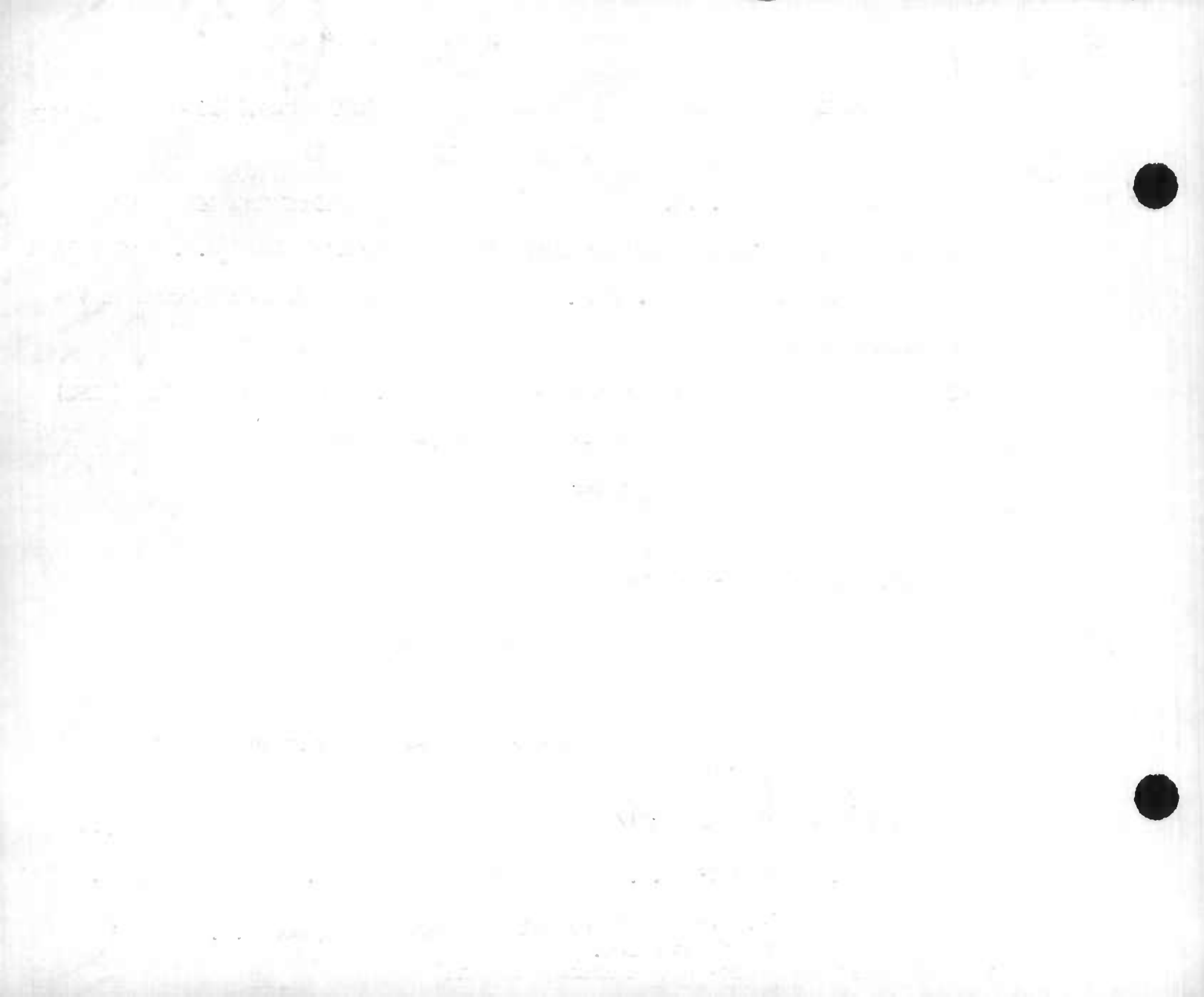
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER WILLIAM LANGE			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 24, 1984		2b. HOUR 8:00 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 13, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Chief U.S. Park Police		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN FT. WASH.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK LANGE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE KINGSBURY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS 579 48 0726 E-1 MARGRETA B. LANGE SAME AS #13 (WIFE)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AdenoCarcinoma of Prostate with DUE TO, OR AS A CONSEQUENCE OF (b) Metastases DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Lt. Lung Bronchopneumonia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from August , 19 84 , to Oct. 24th , 19 84 , that (I) (we) last saw the deceased alive on Oct. 24th , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) (it) did not die the body after death.						
22b. SIGNATURE <i>Victor S. Chupkovich</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/25/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTOR S. CHUPKOVICH M.D.		22e. ADDRESS 9131 Piscataway Rd. #240 Clinton, Md. 20735				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/27/84		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.C. Maryland		23e. DATE REC'D BY REGISTRAR OCT 30 1984				
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc.		25. REGISTRAR'S SIGNATURE <i>Davidson</i>				
6633 Old Alexander Ferry Road Clinton, Maryland						

BP



Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR item 14, per phone 1- STATE REGISTRAR conv. w/FH 11/9/84jlb					8 4 1 6 REG. NO.				
1. DECEASED NAME (TYPE) FIRST MIDDLE LAST Mary R. Langford					2a. DATE OF DEATH MONTH DAY YEAR 10 19 84			2b. HOUR 10:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4606 Hartwick Road 20740	
14. FATHER'S NAME FIRST MIDDLE LAST Millard Filmore Riley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Staats					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-48-5642		17. INFORMANT ADDRESS Address Same as No# 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Senile dementia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Fracture of left inferior pubic ramus</u>									
19a. DATE OF OPERATION <u>10/19</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>19</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>10/19</u> 19 <u>84</u> to <u>10/19</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/19</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <u>Byrl D. Johnson</u>					DEGREE MD			22c. DATE SIGNED 10/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BYRL D. JOHNSON					22e. ADDRESS 4404 Queensbury Rd. Riverdale, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR Francis Gasch's Sons 4739 Baltimore Avenue Funeral Home P.A. Hyattsville, Md. 20781					25a. DATE REC'D. BY REGISTRAR OCT 23 1984				
					25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>				

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 7

FOR
STATE
REGISTRAR

REG. NO.

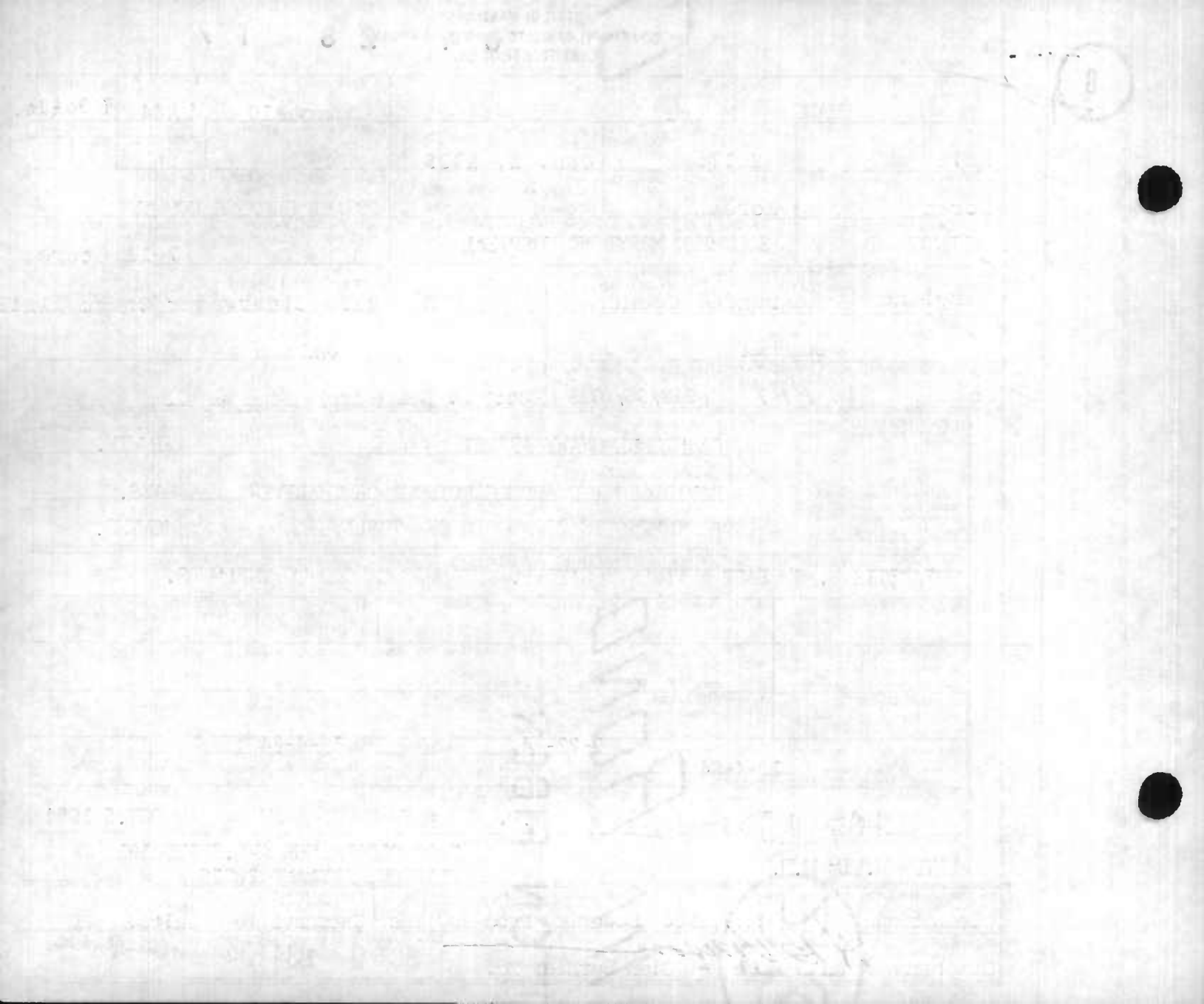
1. DECEASED NAME (TYPE OR PRINT) CHANG Keel LEE			2a. DATE OF DEATH MONTH DAY YEAR October 4, 84		2b. HOUR 9:30 AM
1. SEX Male	4. RACE Yellow	5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1935	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea	7b. CITIZEN OF WHAT COUNTRY? Korean	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales	12b. KIND OF BUSINESS OR INDUSTRY 7-11 Stores	
13a. STATE Maryland			13b. COUNTY AnneArundel	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212/96/0719		17. INFORMANT ADDRESS Betty N. Lee (Wife) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RAPID GROWING ADENOCARCINOMA OF THE LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>POSTNECROTIC CIRRHOSIS OF THE LIVER</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTE. DAYS. MONTHS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HEPATITIS B. SURFACE ANTIGEN POSITIVE. METASTATIC CANCER TO THE LUNGS.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9-22-84</u> , 19____, to <u>10-4-84</u> , 19____, that (I) (we) last saw the deceased alive on <u>10-4-84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE 		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23b. DATE SIGNED OCT. 5 1984	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D.		23d. ADDRESS 7900 OLD BRANCH AVE. SUITE 101 CLINTON, MARYLAND 20735			
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23f. DATE Oct. 7, 1984	23g. NAME OF CEMETERY OR CREMATORY Security Process, Inc.		23h. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR OCT 9 1984	25b. REGISTRAR'S SIGNATURE

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 11 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 1 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM F. LEONBERGER			2a. DATE OF DEATH MONTH DAY YEAR October 21, 1984		2b. HOUR 3:30A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 28, 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 84		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE COUNTRY Washington D.C.		9b. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD		10. CITY OR TOWN OF DEATH Laurel		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Sealtest Dairy		
13a. STATE Maryland		13b. COUNTY Pr Georges		13c. CITY OR TOWN Bowie		
14. FATHER'S NAME FIRST MIDDLE LAST William F. Leonberger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Doehrer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 577-03-6430		17. INFORMANT 5920 4th St. N. Ralph Leonberger; Arlington Va. 22203		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) GASTROINTESTINAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) COLONIAL ARTERY DISEASE		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) COLONIAL ARTERY DISEASE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/21 19 84 to 10/21 19 84 , that (I) (we) last saw the deceased alive on 10/20 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE G. A. COMPTON		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 10/22/84		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 25, 1984		23c. NAME OF CEMETERY OR CREMATORY Andrews Chapel Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax County, Virginia		24. FUNERAL DIRECTOR NAME ADDRESS Colonial Funeral Home Falls Church, Va. 22044				

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOW THE LOCATION OF THE DEATH WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Agnes Hedwig LOPUSZYNSKI			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10-8 1984			2b. HOUR M 11 A 20		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 5, 1899	6. AGE (IN YEARS) (LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-8 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8600 Mike Shapiro Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STREET ADDRESS 8600 Mike Shapiro Dr. 20735					
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Peter Dlugozima			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Cierniska					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-05-1688			17. INFORMANT ADDRESS 6209 Seminole St College Park, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coupled cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) M.D. Deputy			DATE SIGNED 10-8-84		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/10/84		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fort Myer Arlington Virginia	
24. FUNERAL HOME OR OTHER PLACE WHERE FUNERAL SERVICES WILL BE HELD NAME ADDRESS Francis Casch's Sons 4739 Baltimore Avenue Hyattsville, Md. 20781					25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR 3:00am	
		William Hale Lowry Sr.		Male		Cau.		Sept. 23, 1901		83		10/10/84			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U.S.A.				Prince Georges County MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
P.G. County		Southern Maryland Hospital		Maintenance man		U.S. Gov't.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland		P.G.		Cheltenham				10506 Frank Tippet Road							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Jamea Alvin Lowry		Maggie Payne													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS									
NO		216-40-5361		M. Inez Lowry same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MALNUTRITION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ORGANIC BRAINS SYNDROME</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>2/22/84</u> , 19 <u>84</u> , to <u>10/9/84</u> , 19 <u>84</u> that (I) (we) lost saw the deceased alive on <u>10/9/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Andrus Adham</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-10-84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. N. Adham, M.D.				22e. ADDRESS 4467 Old Branch Ave., Temple Hills, Md. 20748											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		10-12-84		Trinity Mem. Gardens		Waldorf, Charles, Md.									
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
Hurt Funeral Home, Waldorf, Md.				OCT 11 1984											

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

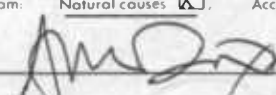
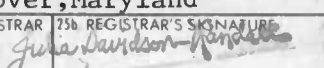
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Sharon Maddox			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 11 19 84			2b. HOUR 4:15 a			
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 29, 1963	6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. XX	IF UNDER 24 HRS. HOURS MIN. XX	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 11 19 84			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Private		
13a. STATE MD.			13b. CITY OR TOWN P.G.		13c. CITY OR TOWN Palmer Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Troy Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Maddox			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. No			17. INFORMANT Emma Smith			ADDRESS Same as Above 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 10/11/84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 Oct. 84		23c. NAME OF CEMETERY OR CREMATORY Harmony Nat'L Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland			
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home				ADDRESS 389 R.I. Ave. N.W. Wash., D.C.		25a. DATE REC'D BY REGISTRAR OCT 26 1984		25b. REGISTRAR'S SIGNATURE 	

JAN 1971

DND



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 2 2

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARGARET C. MADISON		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 31, 19 84 2b. HOUR 4:05A	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan 9, 1932	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. AGE (IN YEARS, LAST BIRTHDAY) 52 YRS. 9. UNDER 1 YEAR MONTHS DAYS HOURS MINS. 10. UNDER 24 HRS. HOURS MINS.	
10. CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF MORE THAN ONE FACILITY, GIVE STREET ADDRESS) DOCTORS HOSP. of P.G.	12. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13c. COUNTY PG	13d. CITY OR TOWN Forestville	13e. STREET ADDRESS / ZIP CODE 24040 Oak Glen Way 20747	
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Fleming		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roseliha August	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --		16b. SOCIAL SECURITY NO. 578-62-2912	
17. INFORMANT ADDRESS Charles P. Madison Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) conductive pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) subacute bacterial pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) subacute bacterial pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) emphysema, chronic APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I, this hospital) attended the deceased from 11/29 19 83 to 10/31 19 84 that (we) last saw the deceased alive on 10/30 19 84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.			
22b. SIGNATURE Lewis H. Dennis, M.D.		22c. DATE SIGNED 10/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Lewis H. Dennis, M.D.		831 University Blvd. E., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2Nov1984	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG Md	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		25a. DATE REC'D. BY REGISTRAR NOV 07 1984	
ADDRESS Suitland, Md.		25b. REGISTRAR'S SIGNATURE Lewis H. Dennis	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and a cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM L. MARSHALL			10/6/84		6:45 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 02/13/13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Public Works
13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William A. Marshall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Smith		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-30-0422
17. INFORMANT ADDRESS 2511 Sansbury Road Upper Marlboro, MD 20772		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-5, 1984 to 10-6, 1984 , that (I) (we) last saw the deceased alive on 10-5, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE A. Mosman		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-6-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MOSMAN		22e. ADDRESS 4235 28th Ave. Temple Hills, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/84		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's MD
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.		ADDRESS 4339 HUNT PLACE, N.E.		CITY WASHINGTON, D.C. 20019		25a. DATE REC'D. BY REGISTRAR 10/15/84
25b. REGISTRAR'S SIGNATURE [Signature]						

WASHINGTON, D.C. 20019
4339 HUNT PLACE, N.E.
ROLLING FUNERAL HOME, INC.

Washington County District

Third District

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 22 must have any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2. REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Sister M. Regina Therese Martin, C.S.C.		2a. DATE OF DEATH MONTH DAY YEAR October 18, 1984	
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1922	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Angela Hall	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nun - Religious	12b. KIND OF BUSINESS OR INDUSTRY Administrator
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3706 Rhode Island Avenue 20712
14. FATHER'S NAME FIRST MIDDLE LAST Elmer H. Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina McCann	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-66-5753	17. INFORMANT ADDRESS Sister Joan Carusillo Mt. Rainier, Md. 20712	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Unknown Primary Site DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months few months			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from SEPT 19 84, to OCT 18 19 84, that (I) (we) last saw the deceased alive on 10/17 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE G. Lennard Gold, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/18/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Lennard Gold, M.D.		22e. ADDRESS 8630 Fenton St. Silver Spring, Md. 20910	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 20, 1984	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.
24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR OCT 22 1984	
25b. REGISTRAR'S SIGNATURE 500 University Blvd., West Silver Spring, Md.			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 2 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAUDE ROSETTA MATTINGLY			2a. DATE OF DEATH MONTH DAY YEAR 10 12 84		2b. HOUR 8:28 PM
3. SEX F Female	4. RACE W Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Clements			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Thompson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ----- 215-36-3850		17. INFORMANT ADDRESS Daughter 4011 74th Avenue Jennie Gibbons, Hyattsville, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RECURRENT INTESTINAL CARCINOMA

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 YEARS

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

ART SC/CAR REN VAS DIS CEREBROVASCULAR ISCHEMIA

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 10/12 19 84, that (I) (we) last saw the deceased alive on 10/4 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE F. W. SCHNEIDER MD		DEGREE		22c. DATE SIGNED 10/12/84	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) F. W. SCHNEIDER		22c. ADDRESS 5401 MACARTHUR BLVD NW DC 20016			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-16-84	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Newport, Charles, Md.
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland		25a. DATE OF REGISTRATION OCT 18 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

Received of J. E. 1991

Central Labor Union
1001 Park St. North, 10782

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Emma Jane Roush McCafferty, C.G.

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 10 28 19 84 7:15 PM

3 SEX
Female

4 RACE
White

5 DATE OF BIRTH
MONTH DAY YEAR 10-2-25 59 YRS.

6 AGE (IN YEARS)
(LAST BIRTHDAY)

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.

7c. DATE PRONOUNCED DEAD 10 28 19 84 7:15 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

OHIO

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S MD

10 CITY OR TOWN OF DEATH

Fort Washington

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

613 Rosier Road

12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY)

GENEALOGIST

12b. KIND OF BUSINESS OR INDUSTRY

GENEALOGY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MARYLAND

13b. COUNTY
PR. GEORGE'S

13c. CITY OR TOWN
FT. WASHINGTON

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS
613 ROSTER ROAD

20744

14. FATHER'S NAME

STANLEY

FERRIS

ROUSH

15. MOTHER'S MAIDEN NAME

DELLA

ANNA

MARIE

GRUBE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

300-18-8582

17. INFORMANT

ADDRESS

JAMES A. McCAFFERTY, HUSBAND, SAME AS #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED

10/28/1984

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct. Camp Springs Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b. DATE

10/30/84

23c. NAME OF CEMETERY OR CREMATORY

METROPOLITAN CREMATORY

23d. LOCATION

ALEXANDRIA

COUNTY

VIRGINIA

24 FUNERAL DIRECTOR RICHARD RAPP, INC.

1804 T ST., N.W., WASHINGTON, D.C. 20009

25a. DATE REC'D. BY REGISTRAR

OCT 31 1984

25b. REGISTRAR'S SIGNATURE

Lelia Davidson-Rendell

RECEIVED
JAN 10 1964

THE UNIVERSITY OF MICHIGAN LIBRARY

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RECEIVED
JAN 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE A. MCCARRON			2a. DATE OF DEATH MONTH DAY YEAR 10 29 84		2b. HOUR 11 15AM						
1. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 11 5 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Pr. George		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12700 Kernwood Lane 20715			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Flaherty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Rothman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 577-48-8856		17. INFORMANT ADDRESS Md. Geoilia Marshall 1220 Van Buren Dr. Ft. Wash					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) proteus mirabilis sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Wound tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Chronic interstitial pneumonia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
APPROXIMATE INTERVAL BETWEEN LAST CAUSE OF DEATH AND DEATH 6 days 6 days											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 6 19 1984 to Oct 29 19 84 , that (I) (we) lost saw the deceased alive on Oct 29 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (saw) the body after death.											
22b. SIGNATURE Leonard P. Appel, M.D.				22c. DATE SIGNED 10-30-84				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS 3231 Superior Lane Bowie, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/2/84		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.			
24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.						25a. DATE REC'D. BY REGISTRAR NOV 5 1984		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. FOR STATE REGISTRAR					2. 8 4 2 8			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERA Louise MCCREA					2a. DATE OF DEATH MONTH DAY YEAR 10 23 84			2b. HOUR 12:45 AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 14, 1912		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72		7. IF UNDER 1 YEAR MONTHS DAYS 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY Dept of Navy	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland	13b. COUNTY PG	13c. CITY OR TOWN Ritchie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2014 Grovewood Drive 20743				
14. FATHER'S NAME FIRST MIDDLE LAST Charles Frederick Calhoun				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Scott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS Betty L. Gargano Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause of Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Negative Septicemia DUE TO, OR AS A CONSEQUENCE OF (c) Hypostatic pneumonia, Renal failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Tr.				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10905 FT. Wash. Rd #207 FT-Wash. Md. 20744				
22a. I certify that (I) (this hospital) attended the deceased from 09/24/84 to 10/23/84 , that (I) (we) last saw the deceased alive on 10/23/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE A-ANSARI MD					22c. DATE SIGNED 10-23-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A-ANSARI MD					22e. ADDRESS 10905 FT. Wash. Rd #207 FT-Wash. Md. 20744			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 26 Oct 1984		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Md.		
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Suitland, Md.					25. DATE REC'D BY REGISTRAR OCT 30 1984			
26. REGISTRAR'S SIGNATURE John E. ...								

BP



192-11-3-0

A33333

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

X

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 4 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Sidney			MIDDLE McHenry			LAST McHenry			7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/19 19 84			7b. HOUR 6:09 A. M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 2, 1901		6. AGE (IN YEARS) (LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/19 19 84			7d. HOUR 6:09 A. M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10. CITY OR TOWN OF DEATH Laurel				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 409 Greenhill Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) labor foreman				12b. KIND OF BUSINESS OR INDUSTRY mineral pigments co					
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 409 Greenhill Avenue 20707									
14. FATHER'S NAME FIRST MIDDLE LAST William A. McHenry						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Noe											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 412 28 3211				17. INFORMANT ADDRESS Lula McHenry same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>John S. Rogers</i>				EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				TITLE (SPECIFY) Deputy 1919 Seminary Road Silver Spring, Montgomery, Md.				DATE SIGNED 10/19/84					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct 22, 1984		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park				23d. LOCATION (CITY OR TOWN) COUNTY STATE Dorsey, Maryland							
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md								25a. DATE REC'D. BY REGISTRAR OCT 25 1984				25b. REGISTRAR'S SIGNATURE					

1

113212

113212



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. REG. NO.	
KIRBY D. MCINTOSH		0000 12 '84		446 AM	
1. SEX		2. DATE OF BIRTH		3. AGE (IN YEARS LAST BIRTHDAY)	
Male		July 14, 1929		55	
1. RACE		3. DATE OF BIRTH		4. IF UNDER 1 YEAR	
Caucasian		July 14, 1929		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Colorado		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Clinton		Southern Maryland Hospital		Training Administrator/ Military	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Prince George's		Clinton	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS	
Lee Roy Mc Intosh		Pearl Jones		7715 Mike Shapiro Dr. (20735)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		Korean Conflict 523-30-3652		Phyllis Mc Intosh - Same As #13 A-E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		RESPIRATORY ARREST		10 MIN.	
DUE TO, OR AS A CONSEQUENCE OF		(b) GLOBLASTOMA MULTIFORME -		5 WEEKS	
DUE TO, OR AS A CONSEQUENCE OF		(c) INFLUENZA - BOTH FROONTAL			
DUE TO, OR AS A CONSEQUENCE OF		(d) WOBES			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
APPROX. 9/15/84		BRAIN BIOPSY - BRAIN TUMOR		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED	
saw the deceased alive on 10/11/84, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		Arthur Shaver, MD		10/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
ARTHUR SHAVER JR MD		9131 PISCATAWAY RD. CLINTON, MD, 20735		John Davidson-Randall	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		October 12, 1984		Lee's Crematory	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS	
Lee Funeral Home, Inc.		Old Alexander Ferry Road, Clinton, Maryland			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
OCT 15 1984					

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28431

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST PHOEBE V. MCKINNEY			MONTH DAY YEAR OCTOBER 14, 1984			A ^M 4:30		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))			7. IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR August 16, 1911	73 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
North Carolina	USA	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Laurel	GREATER LAUREL BELTSVILLE HOSPITAL		housewife			home		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Howard			Jessup		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST Tennessee Howard Jessup			FIRST MIDDLE LAST Mary Mosley			20794 10155 Guilford RD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
no			214 24 2012			Edward Falls 7218 Valley Road, Hanover, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Cardiovascular Disease</u>								<u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, FACTORY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the physician attended the deceased from <u>9/29</u> 19 <u>84</u> to <u>10/14</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/13</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.								
22b. SIGNATURE <u>Dennis R. Schumer MD</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/14/84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Dennis R. Schumer M.D.			14201 Laurel/Park RD, #102 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Oct 16, 1984			Meadowridge Mem. Park Dorsey, Maryland		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Donaldson Funeral Home, Laurel, Md			OCT 25 1984					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or other person at such



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

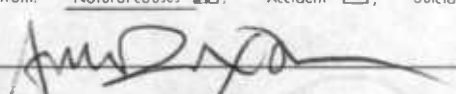
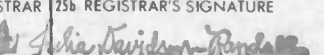
BP

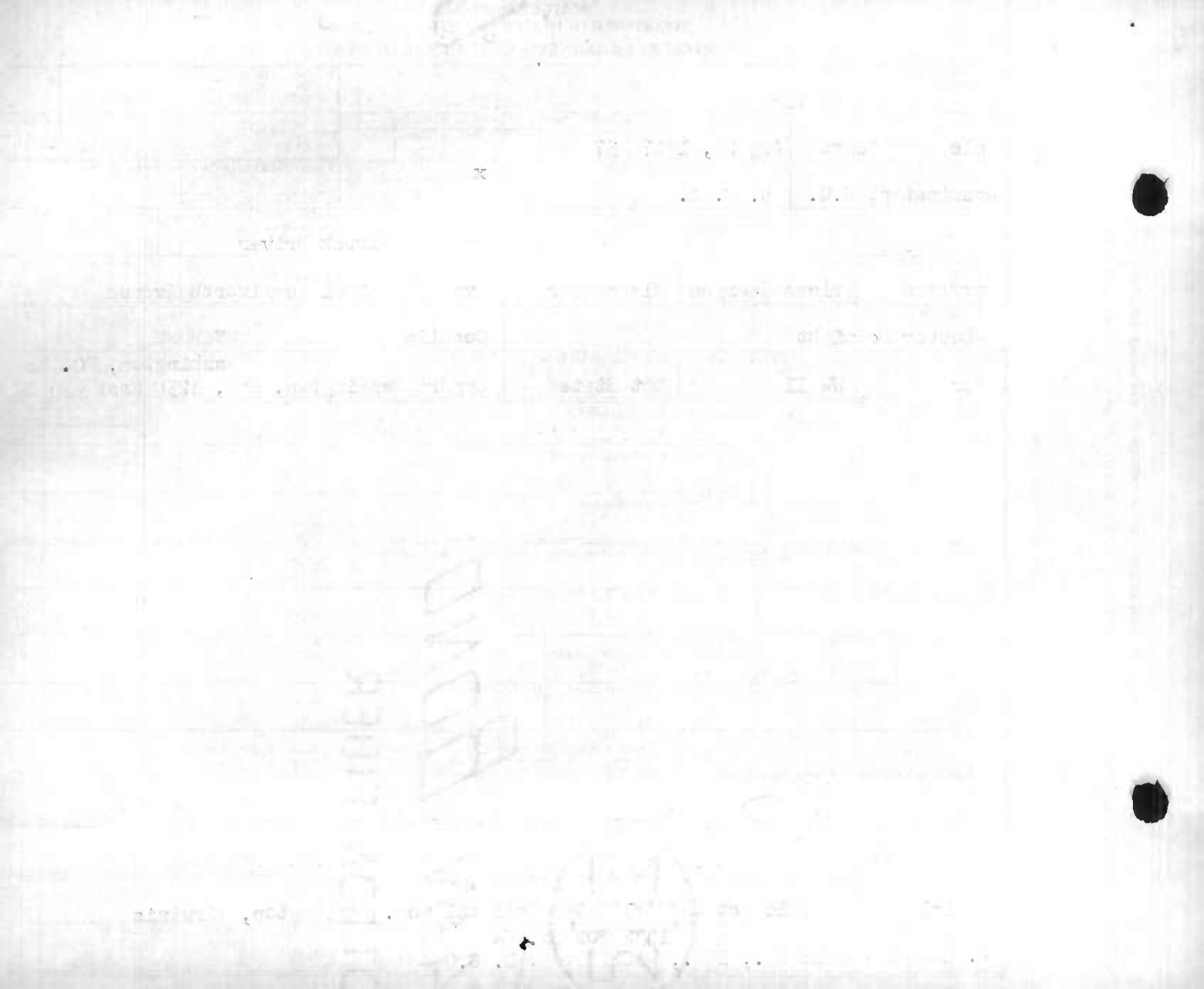
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF DEATH			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH		
FIRST MIDDLE LAST William McKnight			MONTH DAY YEAR 10 10 1984			MONTH DAY YEAR 10 10 1984			MONTH DAY YEAR 10 10 1984			HOUR MIN. 1:46 PM		
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR Aug 28, 1927	6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.								
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver				12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3801 Kenilworth Avenue 20710						
14. FATHER'S NAME FIRST MIDDLE LAST Chester McKnight				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia UNKNOWN										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. Not Stated		17. INFORMANT ADDRESS Washington, DC. NE Sandra Washington, Dau, 4250 East Cap ST						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 10/11/84		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St. Balto., MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 16 Oct 84		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia				
24. FUNERAL DIRECTOR NAME W. ERNEST JARVIS CO., INC.,				ADDRESS 1432 You ST. NW WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR OCT 11 8 1984				25b. REGISTRAR'S SIGNATURE 		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. FOR STATE REGISTRAR					2. 8 4 3 3				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Allean E. McLean					2a. DATE OF DEATH MONTH DAY YEAR October 13, 1984			2b. HOUR 8:00A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 8, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH New Carrollton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5820 Runford Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN New Carrollton		13e. STREET ADDRESS 5820 Runford Drive 20784			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Doss					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Harris				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 408 01 4556		17. INFORMANT ADDRESS Mrs. Peggy M. Condee Address Same as No# 13e.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) 10 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 10-8-84 to 10-13-84 , that (1) was last saw the deceased alive on 10-8-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or did) (didn't) view the body after death.									
22b. SIGNATURE Angus W. McLaurin, M.D.					22c. DATE SIGNED 10/13/84			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Angus W. McLaurin, M.D.					22f. ADDRESS 3415 Hamilton Street - Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 16, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland					25a. DATE RECEIVED BY REGISTRAR OCT 15 1984		25b. SIGNATURE John Gordon		



1964 OCT 15

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Carlton Lang Mears</i>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>Oct 5 1984</i>		2b. HOUR MIN SEC <i>9:25</i>
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Sept 19 18 61</i>	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN <i>22 YRS</i>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Oct 6 19 84</i>	7d. HOUR MIN SEC <i>2:25</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Backbone Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>AGENT</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Prince Georges</i>	13c. CITY OR TOWN <i>Seabrook</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>6012 99th Ave</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Loyliss Mears</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Lula Lang</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>078-10-9950</i>		17. INFORMANT ADDRESS <i>Marion L. Mears 6812 99th Ave. Seabrook, Md. 20706</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Chronic Myocardial Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hrs</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>					
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) <i>Dep.</i>		DATE SIGNED <i>Oct 6/ 1984</i>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Oct. 9, 1984</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>
24. FUNERAL DIRECTOR NAME <i>Howard Hale's Lanham Funeral Home</i>			25a. DATE REC'D. BY REGISTRAR <i>Oct 9 1984</i>		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			25c. REGISTRAR'S NAME <i>[Signature]</i>		
26. ADDRESS <i>9013 Annapolis Rd., Lanham, Md. 20706</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leo S. MILLER			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10-13 1984			2b. HOUR 8:00					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-05-19 65 YRS		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Police Officer			12b. KIND OF BUSINESS OR INDUSTRY Police		
13a. STATE Delaware			13b. CITY OR TOWN Sussex			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS 22 F Laws Point Road		
14. FATHER'S NAME FIRST MIDDLE LAST Anthony W. Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Esther			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 578-16-1240		
17. INFORMANT Mildred Miller, Same As #13 A-E			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 10-13-84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Shock						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 10-13-84		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 18, 1984			23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Maryland		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR OCT 15 1984					
ADDRESS 6633 Old Alexander Ferry Road, Clinton, Maryland						25b. REGISTRAR'S SIGNATURE Davidson-Randall					



RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST LORRAINE MARIE MILLER				2b. HOUR 2:10p.m.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1954		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF P.G.Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY N/A	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Theodore Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Rose America			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Father ADDRESS Box 23-A Ralph T. Miller, Avenue, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION <u>9/13/84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Placement of Peritoneal catheter</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> 19 <u>84</u> to <u>10/4</u> 19 <u>84</u> , that (we) last saw the deceased alive on <u>10/4</u> 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) see the body after death.							
22b. SIGNATURE <u>Steven M Pullar MD</u>				22c. DATE SIGNED <u>10/5/84</u>		22d. ATTENDING PHYSICIAN MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven M Pullar MD</u>				22f. ADDRESS <u>4700 AUTH Place CAMP SPRING</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-8-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Md.	
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Maryland				25. DATE RECEIVED BY REGISTRAR 8/10/84 REGISTRAR'S SIGNATURE <u>Waldorf</u>			

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FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Louise E Miller			2a. DATE OF DEATH MONTH DAY YEAR 10 15 84			2b. HOUR 12:15 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1945		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (IF)) Clerk of Court		12b. KIND OF BUSINESS OR INDUSTRY Pr. Geo County	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland PG					13b. CITY OR TOWN Temple Hills		13c. STREET ADDRESS / ZIP CODE 5109 Lorraine Drive 20748		
14. FATHER'S NAME FIRST MIDDLE LAST Chester J. Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Kerr					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Allen L. Miller Same as #13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **NON HODGKINS LYMPHOMA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)21d. INJURY OCCURRED WHITE ☐ NOT WHITE ☐ AT WORK ☐ AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21e. PLACE OF INJURY STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **1975**, 19 **8**, to **Oct 14**, 19 **84**, that (I) (we) lost saw the deceased alive on **Oct 14**, 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED **10/15/84**22d. PHYSICIAN'S NAME (TYPE OR PRINT) **J. CARUSO M.D.** 22e. ADDRESS **9131 Piscataway Rd., CLINTON, Md.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 18 Oct 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24. FUNERAL DIRECTOR NAME ADDRESS Robert E. Wilhelm Funeral Home				25a. DATE REC'D. BY REGISTRAR OCT 22 1984 25b. REGISTRAR'S SIGNATURE Galia Davidson-Randall			

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

 Copy of certificate to Dr. Rodriguez
 DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 3 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth H. Moffat			2a. DATE OF DEATH MONTH DAY YEAR October 8, 1984			2b. HOUR 2:30a				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 22 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. UNDER 1 YEAR MONTHS DAYS 7 10		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hyattsville Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bond Exam Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government		
13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Herbert J. Moffat			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie V. Spicer			13e. STREET ADDRESS / ZIP CODE 4100 Emerson Street 20781				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-54-6154		17. INFORMANT Robert W. Bongers				ADDRESS 12604 Prospect Knoll Dr. Bowie, Maryland 20715	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Senility ② possible sepsis DUE TO, OR AS A CONSEQUENCE OF (b) ③ Chronic Constipation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF Hypertensive Cardiovascular disease (c) diarrhea									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a degenerative Arthritis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10.8.84 to 10.8.84 , that (I) (we) lost saw the deceased alive on 10.8.84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H.A. Molau, M.D.					DEGREE M.D.			22c. DATE SIGNED 10.8.84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.A. MOLAU, M.D.					22e. ADDRESS 6005 Landover Rd. Chevy Chase, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/11/84		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg P.G. Maryland		
24. FUNERAL DIRECTOR'S NAME Francis Casch's Sons										
25. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781										

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10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 3 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (Type or Print) ANNA Marie S. MORGAN			2a. DATE OF DEATH MONTH DAY YEAR 10 28 84		2b. HOUR 12:35am
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Aug. 1 st 1895	6. AGE (IN YEARS LAST BIRTHDAY) 89	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) USA Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD COUNTY MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bindery worker	12b. KIND OF BUSINESS OR INDUSTRY US Gov't Print. OFF.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE, 13b. COUNTY, 13c. CITY OR TOWN Virginia Fairfax Annandale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William C. Sproesser			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Clune		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 577-24-9052M	17. INFORMANT ADDRESS Joseph A. Morgan/4207 Sleepy Hollow Rd. Annandale, Va. 22003		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CEREBRAL HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF

(b)

CEREBROVASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(c)

ARTERIOSCLEROTIC DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

CARDIOMEGALY, ATRIAL FIBRILLATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-21, 1984, to 10-28, 1984, that (I) (we) last saw the deceased alive on 10-27, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE R. Samtani	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-29-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. SAMTANI, M.D.		22e. ADDRESS 9015 Woodyard Rd, Clinton, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/31/84	23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.
24. FUNERAL DIRECTOR NAME ADDRESS Murphy Funeral Home/4510 Wilson Blvd. Arlington, VA		25a. DATE REC'D. BY REGISTRAR OCT 31 1984	25b. REGISTRAR'S SIGNATURE John Davidson-Rendell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use at the burial-transit permit. Then please remove cause-of-death, pages 3 and 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical certificate must be completed by the medical officer.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Charles Thomas MORRIS				October 29 1984				6:35am			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
MALE		BLACK		SEPT. 9, 1929		55		YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
ALA.		U.S.A.				PRINCE GEORGES MD.					
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
LANHAM		DOCTOR'S HOSP. OF P.G.		UNEMPLOYED		NONE					
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
MD.				P.G.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7751 BURNSIDE DR. 20785			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
UNKNOWN				UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				UNKNOWN		SHEILA KLOD - SAME AS #13 ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF, (b) Union of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF, (c) Alcoholic hepatitis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
		Intestinal obstruction				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2		21e. PLACE OF INJURY					
		P.M. 19				21f. LOCATION					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21g. CITY OR TOWN					
						COUNTY					
						STATE					
22. I certify that (I) (this hospital) attended the deceased from 10/2/84, 19, to 10/24, 1984, that (I) (we) lost saw the deceased alive on 10/27, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
M. K. MOHAN				M.D.				10/30/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
M. K. MOHAN				6510 Kehilwork Ave				20737			
23. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
				11/3/84		HARMONY MEM. PARK		HIGHLAND PARK, P.G. MD.			
24. FUNERAL DIRECTOR				25. DATE REC'D BY REGISTRAR				25. REGISTRAR'S SIGNATURE			
NAME				ADDRESS							
H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E.				NOV 13 1984				John Davidson			

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 4 1

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clyde Douglas Morris			2a. DATE OF DEATH MONTH DAY YEAR 10 12 84		2b. HOUR 11 15 P M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SICK FACILITY, GIVE STREET ADDRESS) 8418 Rambler Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Mechanic			
13a. STATE Colorado				13b. CITY OR TOWN Boulder		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2685 28th Street			
14. FATHER'S NAME FIRST MIDDLE LAST William C. Morris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Dow							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 522-07-9597		17. INFORMANT 8418 Rambler Dr, Adelphi, Md. 20783 Mrs. Charlotte E. Dennis, Daughter					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Widely metastatic adenocarcinoma probably pancreatic

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Weeks

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Recent onset of Diabetes Mellitus

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 10/3, 19 84, to 10/12, 19 84, that (I) (we) lost saw the deceased alive on 10/3, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Byrl D. Johnson				DEGREE MD		22c. DATE SIGNED 10/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BYRL D. JOHNSON				22e. ADDRESS 4404 Queensbury Road Riverdale, Md. 20707			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/17/1984		23c. NAME OF CEMETERY OR CREMATORY Mt. View Mem'l Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Boulder, Boulder, Colorado	
24. FUNERAL DIRECTOR (NAME) Helen M. Johnson				25a. DATE REC'D. BY REGISTRAR 10/16/84			
25b. REGISTRAR'S SIGNATURE Helen M. Johnson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

REPORT OF SPECIAL AGENT IN CHARGE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harrison L. Moore			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1984		2b. HOUR 6:05A.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 622 10th Street 20707	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha M. Levi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-09-6757	17. INFORMANT ADDRESS Margaret Moore (sister) same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT WITH COMPLETE BLOCK DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PERIPHERAL VASCULAR DISEASE, POST CVA + SEIZURE DISORDER					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 83 to PRESENT, 19 _____, that (I) (we) last saw the deceased alive on 9 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. CASAS FOR DR. G. COMATON		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
L. CASAS FOR DR. G. COMATON		14201 LAUREL PK. W. #222 LAUREL MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-8-84	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Jessup, Howard, Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, Md 20850		25. DATE REC'D. BY REGISTRAR OCT 8 1984	
		25b. REGISTRAR'S SIGNATURE Julia Davidson			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) Kenneth L. Moore, Jr.						2a. DATE KNOWN OF DEATH XX MONTH 10 DAY 20 YEAR 1984		2b. HOUR 5:00 P.M.			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH Nov. DAY 29 YEAR 1983	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 11	IF UNDER 1 YR MONTHS 11 DAYS 11	IF UNDER 24 HRS. HOURS 11 MIN 11	7c. DATE PRONOUNCED DEAD 10-20 1984		7d. HOUR 5:00 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co., MD.					
10. CITY OR TOWN OF DEATH Marlboro		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8307 Croom Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8307 Croom Rd.			
14. FATHER'S NAME FIRST Kennehh MIDDLE L. LAST Moore, Sr.				15. MOTHER'S MAIDEN NAME FIRST Brenda MIDDLE L. LAST Berry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Brenda L. Berry-Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dennis F. Smyth		TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER				DATE SIGNED 10-21-84					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/24/84		23c. NAME OF CEMETERY OR CREMATORY MYERS CH. CEM.		23d. LOCATION CITY OR TOWN CROOM, P.G. COUNTY P.G. STATE MD.					
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS ADDRESS 4925 BURROUGHS AVE.				25a. DATE REC'D. BY REGISTRAR JUL 25 1984		25b. REG. NO. 10-21-84					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA G. MOORE			2a. DATE OF DEATH MONTH DAY YEAR 10 28 84		2b. HOUR 5 : 40 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5-7-1940		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP & MC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist	12b. KIND OF BUSINESS OR INDUSTRY P.G. Hospital	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph E. Moore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Burroughs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-56-4443		17. INFORMANT ADDRESS Mary Higgs 14217 Springfield Road Brandywine Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction. DUE TO, OR AS A CONSEQUENCE OF (c) Sarcoidosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Sepsis Renal Failure Small Bowel Perforation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from August 7, 1984, to October 28, 1984, that (I) (we) last saw the deceased alive on October 28, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE Stephen P. Crossland, M.D.		DEGREE		22c. DATE SIGNED 10/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5632 ANNAPOLIS Rd. #10 Bladensburg, Md. 20710			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-2-84	23c. NAME OF CEMETERY OR CREMATORY Asbury Ch.		23d. LOCATION CITY OR TOWN COUNTY STATE Brandywine P.G. Md	
24. FUNERAL DIRECTOR NAME ADAMS F.H. PA AQUASCO MARYLAND 20608		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE NOV 07 1984	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4-82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Catherine Ann Moss			2a. DATE KNOWN OF DEATH ESTIMATED 10-13-84		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1-13-98	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 10-13-84
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.
10. CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DRIVE 3319 Huntley Square T-2		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS T-2 20748 3319 Huntley Square Dr.
14. FATHER'S NAME FIRST MIDDLE LAST John Carney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Larkin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----578-28-3334		17. INFORMANT Ft. Washington, Md. 20744 Patricia Burch, 8014 Murray Hill Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Arthritis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		TITLE (SPECIFY) Deputy		DATE SIGNED 10-13-84	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-17-84	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pittsburgh, Alleg. Pa.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md.			25a. DATE REC'D. BY REGISTRAR OCT 16 1984		25b. REGISTRAR'S SIGNATURE <u>Jana Davidson Handall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or if the deceased was any injury, or other traumatic event, the medical examiner must be notified.

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVERETT MULLINS JR			2a. DATE OF DEATH MONTH DAY YEAR OCT 8 84			2b. HOUR 06:43 AM			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 3 15 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY US Army	
13a. STATE Maryland			13b. COUNTY Pr. George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Everett Mullins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McCormick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII, Korea 236-01-0957		17. INFORMANT ADDRESS Mary Y. Mullins same as item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) <input checked="" type="checkbox"/> Critical Aortic Stenosis DUE TO, OR AS A CONSEQUENCE OF (c) <input checked="" type="checkbox"/> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3 OCTOBER 1984 to 8 OCTOBER 1984 , that (I) (we) last saw the deceased alive on 8 OCTOBER 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE JAMES NEVILLE			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8 OCT 1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES S. NEVILLE			22e. ADDRESS Malcolm Grow Medical Center						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/12/84		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.		
24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.					25a. DATE REC'D. BY REGISTRAR OCT 11 1984				
25b. REGISTRAR'S SIGNATURE <i>Richard R. Riddell</i>									

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28447

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUTHER H MUMFORD			2a. DATE OF DEATH MONTH DAY YEAR 10 31 84			7b. HOUR 9.24pm M	
3. SEX M MALE		4. RACE W WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07-14-08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED CHIEF COPYRIGHT OFFICE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND PRINCE GEORGES CLINTON				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE U.S. GOVERNMENT 9007 BALLARD LANE 20735	
14. FATHER'S NAME FIRST MIDDLE LAST LUTHER H. MUMFORD SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NATA BLAYLOCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS MARJORIE A. MUMFORD (Wife) Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) INTERCUTANEOUS MYOCARDIAL INFARCTION 4 DAYS DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO/WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 8 19 61 to Present , that (I) (we) last saw the deceased alive on 08/31/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur Shaver MD				22c. DATE SIGNED 10/31/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR SHAVER JR MD	
22e. ADDRESS 9131 PISCATAWAY RD CLINTON, MD 20735							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/5/84		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY Clinton P.G. Maryland 20735	
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME INC.				25a. DATE REC'D. BY REGISTRAR NOV 9 1984			
25b. ADDRESS 6633 Old Alexander Ferry Road Clinton Maryland							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

20

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDITH REBECCA MYERS			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 1, 1984			2b. HOUR 3:30p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.			
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE Maryland 13b. COUNTY Pr. Geo's 13c. CITY OR TOWN Upper Marlboro 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 3112 Pyles Dr / 20772									
14. FATHER'S NAME FIRST MIDDLE LAST James W. Loveless				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annastacia -- Moran					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-28-5942		17. INFORMANT ADDRESS 3112 Pyles Dr., Thomas E. Myers, Sr. - Upper Marlboro, Md. 20772			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fracture</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Fracture</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>9/15</u> , 19 <u>84</u> , to <u>10/1</u> , 19 <u>84</u> , that (2) we last saw the deceased alive on <u>9/30</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death)									
22b. SIGNATURE <u>Robert Ruderman MD</u>				22c. DATE SIGNED 10/1/84				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Ruderman MD	
22e. ADDRESS 6510 KENILWORTH AVE. Riverdale, MD				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/5/84		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood (Pr. Geo's) Md.		
24. FUNERAL DIRECTOR Richard A. Coleman -- Upper Marlboro, Md. 20772						25a. DATE REC'D. BY REGISTRAR OCT 4 1984		25b. REGISTRAR'S SIGNATURE <u>Susan Davidson Handell</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Gleason MYERS			2a. DATE OF DEATH MONTH DAY YEAR October 20, 1984			2b. HOUR PM 12:20 M	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12227 Wynnmore Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor	
						12b. KIND OF BUSINESS OR INDUSTRY US Government	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Pr George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						13e. STREET ADDRESS / ZIP CODE 12227 Wynnmore Lane 20715	
14. FATHER'S NAME FIRST MIDDLE LAST John Gleason Myers, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Winifred Agnes Pollard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Ruth E. Myers		17a. ADDRESS 12227 Wynnmore Lane Bowie, Maryland 20715	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medical Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Recurrent Liposarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Respiratory arrest</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 10</u> , 19 <u>81</u> , to <u>Oct. 20</u> , 19 <u>84</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>Sept. 19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Abdul Q. Ahad</u>						22c. DATE SIGNED Oct. 22, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Abdul Q. Ahad, M. D.						22e. ADDRESS 3327 Superior Lane Suite 102, Bowie, MD 20715	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 23, 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. Cheltenham, Pr. George's, MD		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		24b. ADDRESS 16000 Annapolis Road Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR OCT 25 1984		25b. REGISTRAR'S SIGNATURE <u>Alia Davidson</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by mail.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOSEPH H. NICHOLS, JR.				2a. DATE OF DEATH MONTH OCTOBER DAY 19 YEAR 1984		
3. SEX Male		4. RACE White		2b. HOUR 12:17pm		
5. DATE OF BIRTH MONTH May DAY 23 YEAR 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. Co		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Eng.		
13a. STATE Maryland		13b. COUNTY P.G.		13c. STREET ADDRESS / ZIP CODE 3800 40th. Ave. 20722		
14. FATHER'S NAME FIRST Joseph MIDDLE H. LAST Nichols, Sr.		15. MOTHER'S MAIDEN NAME FIRST Georgia MIDDLE E. LAST Sonnenberg		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy		
16b. SOCIAL SECURITY NO. W.W.II		17. INFORMANT Mrs. Inez F. Nichols		17. ADDRESS Address Same as No# 13c.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinomatosis peritonei. DUE TO, OR AS A CONSEQUENCE OF (b) aden Carcinoma of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Stroke					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 10/19 19 84 to 10/19 19 84 , that (I) (we) last saw the deceased alive on 10/19 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.						
22b. SIGNATURE T. Chace				22c. DATE SIGNED 10/19/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. CHACE				22e. ADDRESS 24 Cunningham Drive Bowie, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/22/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		
23d. LOCATION CITY OR TOWN Brentwood COUNTY P.G. STATE Maryland		24. NAME OF FUNERAL HOME Francis Gasch's Sons		25a. DATE REC'D. BY REGISTRAR OCT 23 1984		
24. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781		25b. REGISTRAR'S SIGNATURE Johanna Davidson-Randall				

Male	White	May 22, 1932	63
Female	U.S.A.	X	
Maryland	Cottage City	X	3800 40th. av. 20720
Joseph	Nichols, Sr. Joseph	F.	Somerset
Verity	284-12-1211 John F. Nichols	No. 156.	Adrian Lane 28

Handwritten notes and signatures:
 Total of 1000
 2000
 2000

x

Large handwritten signature and notes at the bottom of the page.

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 DINO

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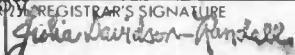
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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B above, injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUBY NICHOLSON				2a. DATE OF DEATH MONTH DAY YEAR 10-31-84			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 2, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY 10-16			
13c. CITY OR TOWN Landover, Md		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7208 Flagstaff Street 20785			
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Snowden		ADDRESS Landover, Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-56-0805		17. INFORMANT Herbert Nicholson/ Husband/7208 Flagstaff St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Liver Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Primary Unknown DUE TO, OR AS A CONSEQUENCE OF (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Diabetic Mellitus, Chronic End Stage Renal Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/20/84 to 10/31/84 , that (I) (we) last saw the deceased alive on 11/29/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-31-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASWINDER S. SIDHU M.D.		22e. ADDRESS 4700 AUTH PL. CAMP SPRINGS, MD 20031					
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL		23b. DATE 11/5/84		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Maryland	
24. FUNERAL DIRECTOR'S NAME JOHN T. RHINES COMPANY				25a. DATE REC'D. BY REGISTRAR NOV 14 1984			
24b. ADDRESS FUNERAL HOME				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 28452							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter George Nieman						2a. DATE OF DEATH MONTH DAY YEAR 10 13 84		2b. HOUR 3:10p _M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 2 06		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Largo		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care of Largo				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Army Corp Eng.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Herman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Langemeier		13e. STREET ADDRESS / ZIP CODE 131 Greenhill Road 20770					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 502-07-0980		17. INFORMANT ADDRESS Ethel Nieman (Wife) Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> 19 <u>84</u> to <u>10/13</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/12</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Barry Rosenberg</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>10/14/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Rosenberg		22e. ADDRESS 6501 Landover Rd., Cheverly, Md. 20785							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/18/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR Francis Gasch's Sons 4739 Baltimore Avenue Funeral Home P.A. Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

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Oct 12 1944

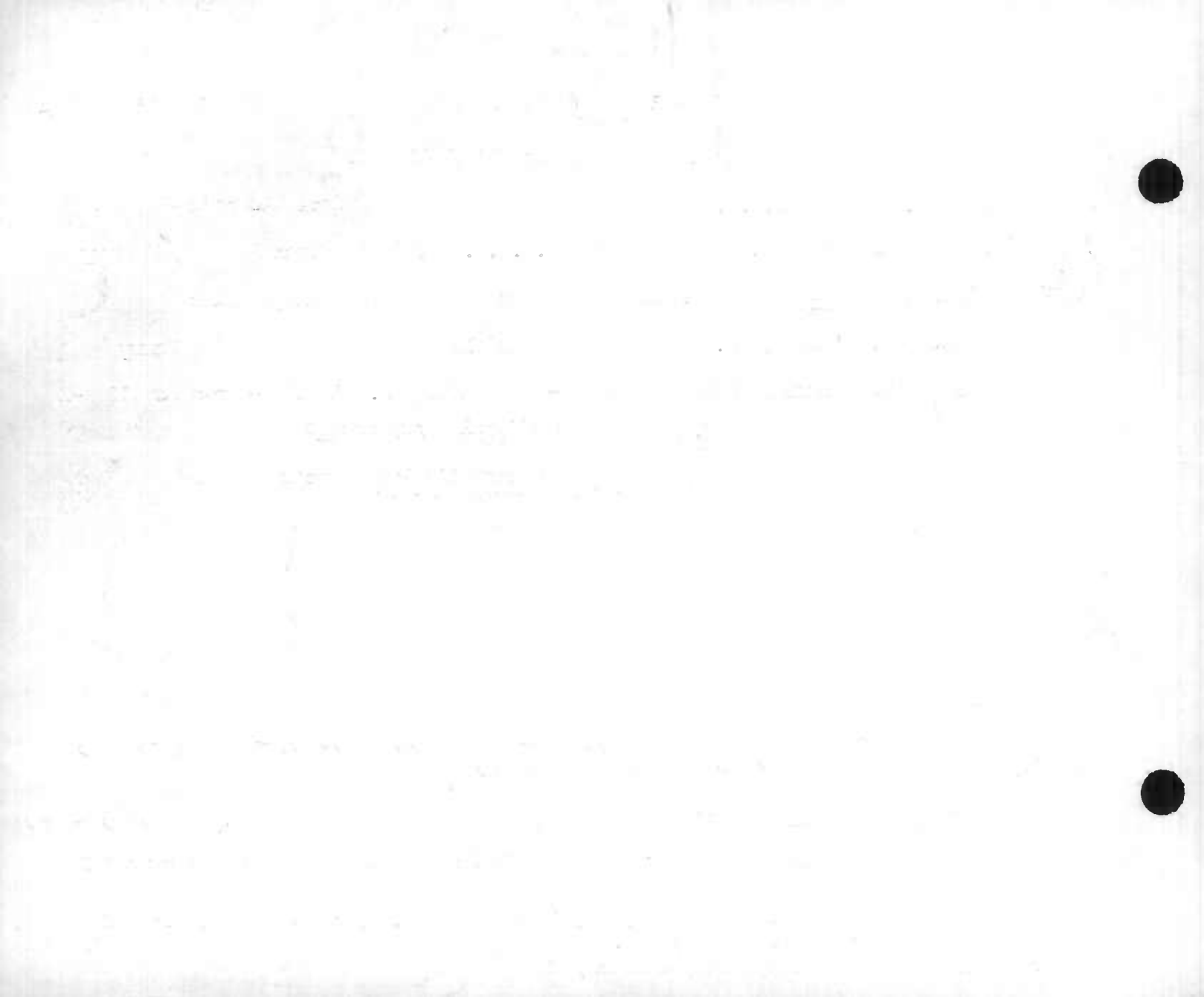
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hour of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TIMOTHY FRANCIS O'KEEFE			2a. DATE OF DEATH MONTH DAY YEAR 10 14 84		2b. HOUR 0840A
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 18, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.	
10. CITY OR TOWN OF DEATH Andrews Air Force Base	NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow U.S.A.F. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General	12b. KIND OF BUSINESS OR INDUSTRY Military	
13a. STATE Florida	13b. COUNTY Bay	13c. CITY OR TOWN Florida	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3111 Kings Drive 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Timothy F. O'Keefe, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adele Ferry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII, Korea, Viet Nam 133-07-5804		17. INFORMANT ADDRESS Eileen P. O'Keefe - Same As #13 A-E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lung cancer METASTATIC LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. I certify that (i) (this hospital) attended the deceased from 16 SEPT , 19 84 , to 14 OCT , 19 84 , that (ii) (we) last saw the deceased alive on 13 OCT , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) did (did not) view the body after death.					
22. SIGNATURE Dennis T. Alter		DEGREE M.D.		22b. DATE SIGNED 14 OCT 84	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS T. ALTER		22c. ADDRESS Malcolm Grow USAF Med Gen, Andrews AFB			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE October 17, 1984	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, VA		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE Jane Davidson-Rendell	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer A. Olmstead			2a. DATE OF DEATH MONTH DAY YEAR October 17, 1984		2b. HOUR 9:50P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 4, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Machinist	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank Olmstead			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Carey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT 20405-McCracken Dr. John A. Olmstead Dunkirk, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Transmural Anterior MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE Heart Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u>					
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10. 11. 1984</u> to <u>10. 17. 1984</u> , that (I) (we) last saw the deceased alive on <u>10. 17. 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>C. Delina</u>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10. 18. 84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE DELINA		22e. ADDRESS 14201 LANCE PE DE LANCE MD 20810			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-20-84	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR OCT 19 1984	25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>

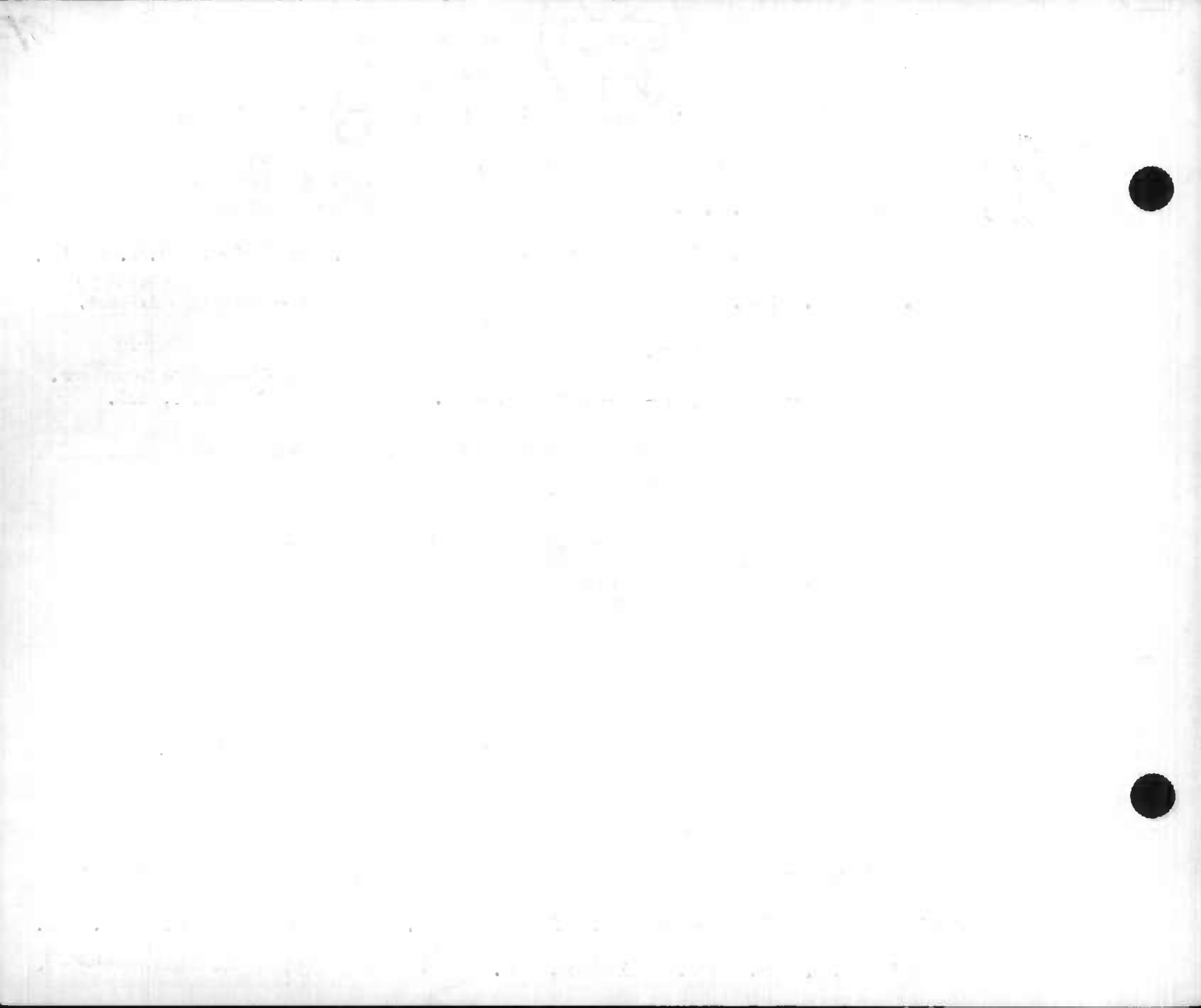
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, does any injury, or other traumatic event, the medical certificate must be filed with the death certificate.

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 3 FOR BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Lisa Dawn Oriani			MONTH DAY YEAR 10-7 1984			M 6:20 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
Female	White	MONTH DAY YEAR March 24, 1963	21 YRS.	MONTHS DAYS HOURS MIN.	10-7 1984			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.		U.S.A.				Prince George's County, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George's General Hospital		Stock Clerk		Giant Food		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
Maryland	Pr. Geo.	Beltsville	YES <input type="checkbox"/> NO <input type="checkbox"/>	20705 11332 Cherry Hill Road # 203				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
FIRST MIDDLE LAST Frank L. Oriani			FIRST MIDDLE LAST Janet S. Schureman			17. INFORMANT ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			218-90-2740			Janet S. Oriani Mother Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Multiple Injuries								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR 2:35 10-7 1984		pedestrian struck by auto			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			road		34th blk. Powder Mill Rd., Beltsville, Prince George's Co., Md.			
22a. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Dennis F. Smyth, M.D.			M.D. Assistant			10-8-84		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Dennis F. Smyth, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		Oct. 12, 1984		George Washington		City or Town County State Adelphi Pr. Geo. Maryland		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis J. Collins				OCT 15 1984		Julia Davidson-Randall		
500 University Blvd., W. Silver Spring, Md.								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
200A 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARY J. OWENS							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-7 1984		2b. HOUR		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH (MONTH DAY YEAR) OCT. 27, 1963		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 20 YRS.		7c. DATE PRONOUNCED DEAD 10-7 1984		7d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEWFOUNDLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES				10. CITY OR TOWN OF DEATH CHEVERLY				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN				12b. KIND OF BUSINESS OR INDUSTRY FOOD SERVICE				13a. STATE MARYLAND			
13b. CITY OR TOWN ST. MARY'S				13c. CITY OR TOWN ST. INIGOES				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS STAR ROUTE, BOX 5				13f. CITY OR TOWN 20684				14. FATHER'S NAME FIRST MIDDLE LAST JACK D. OWENS			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH BERGKESSEL				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES 1980-1983				16b. SOCIAL SECURITY NO. 213-92-1104			
17. INFORMANT EDITH M. OWENS, STAR ROUTE, BOX 5, ST. INIGOES, MARYLAND				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE INJURIES Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 7 8151 (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION 10-6-84				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? INJURIES				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:35 P.M. 10-6 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) PASS. & AUTO IMPACT/FIXED OBJECTS			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET				21f. LOCATION CITY OR TOWN COUNTY STATE RT. 235, LEXINGTON PARK ST. MARYS, MD.				22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) DEPUTY				DATE SIGNED 10-8-84			
EXAMINER'S NAME AUGUSTO P. RODRIGUEZ, M.D.				ADDRESS 5009 RAYBURN CT. CAMP SPRINGS, MD 20748				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			
23b. DATE 10-10-84				23c. NAME OF CEMETERY OR CREMATORY ST. PETER CLAVER				23d. LOCATION CITY OR TOWN COUNTY STATE ST. INIGOES, ST. MARY'S, MD.			
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.				25a. DATE REC'D. BY REGISTRAR 11-1-84				25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Kenneth H Owens			2a. DATE OF DEATH MONTH 10 DAY 14 YEAR 84			2b. HOUR 5¹⁰ P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH September DAY 12 YEAR 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk - Postal		12b. KIND OF BUSINESS OR INDUSTRY Postal				
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? NO		13e. STREET ADDRESS 5511 Fisher Road (20748)	
14. FATHER'S NAME FIRST Leonard M. MIDDLE Owens LAST Owens			15. MOTHER'S MAIDEN NAME FIRST Delilah MIDDLE Rohrer LAST Rohrer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 578-05-5933		17. INFORMANT Mildred Owens - Same As #13 A-E			ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF, (c) Chronic Pyelonephritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 8 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Pyelonephritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/21/84 to 10/14/84 , that (I) (we) last saw the deceased alive on 9/21/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE J. Sanford Young, M.D.				DEGREE MD		22c. DATE SIGNED 10/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Sanford Young, M.D.				22e. ADDRESS 11701 Livingston Road Fort Washington, Maryland 20735			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 19, 1984		23c. NAME OF CEMETERY OR CREMATORY Welsh Church Cemetery		23d. LOCATION CITY OR TOWN Madison County, New York COUNTY New York STATE New York	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS Old Alexander Ferry Road, Clinton, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified by phone).

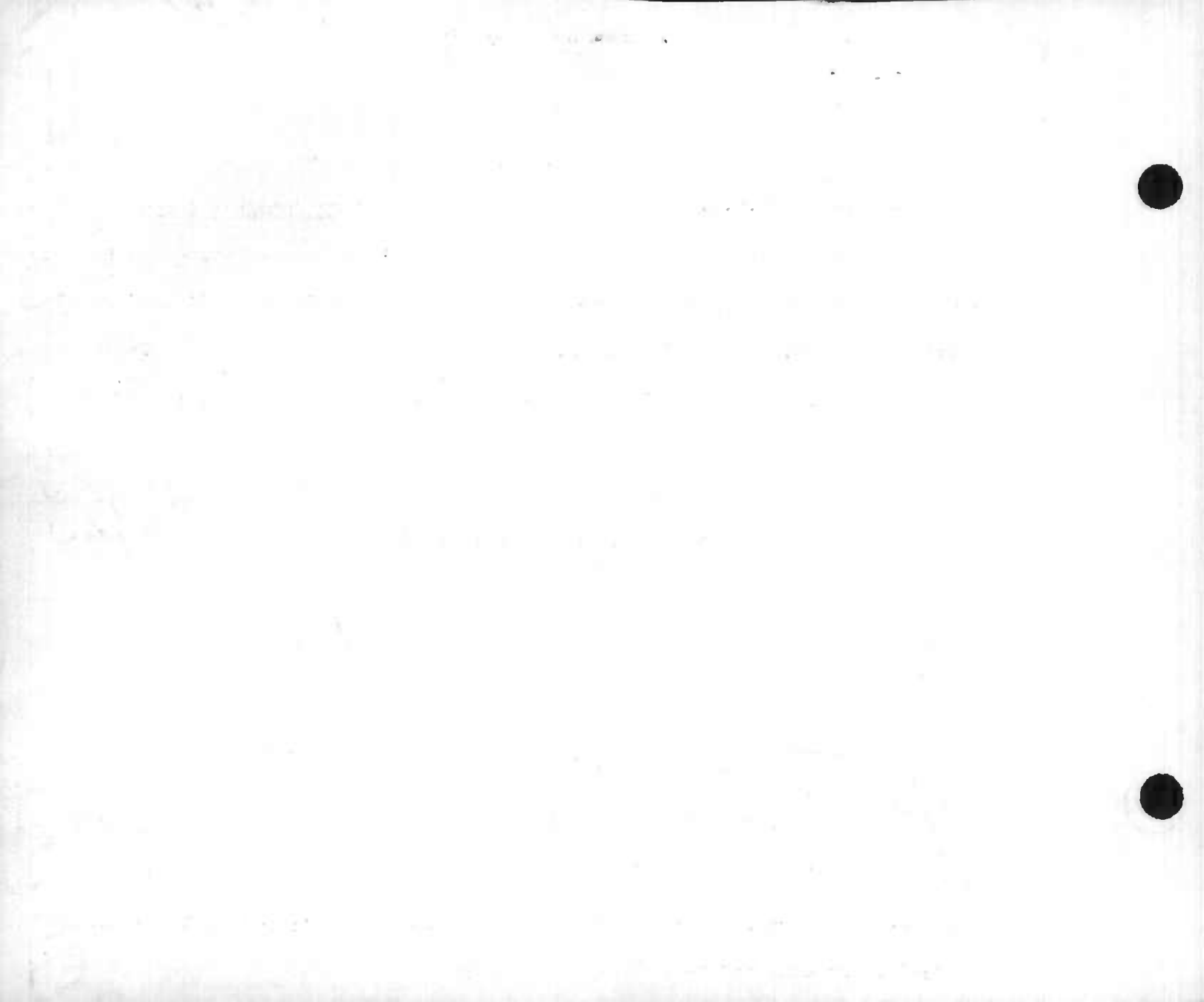
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LARRY A. OWENS			2a. DATE OF DEATH MONTH DAY YEAR 10 27 84		2b. HOUR 9:47P M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1940	6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP. & MC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lunch Truck Operator / Service		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince Georges/Brentwood	13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 4142 Bunker Hill Road/20722
14. FATHER'S NAME FIRST MIDDLE LAST John F. Owens, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Hewitt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unavailable	17. INFORMANT (wife) Barbara V. Owens ADDRESS 10 Franklin Ave. Harrison, NJ 07029			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Scleroderma Heart DUE TO, OR AS A CONSEQUENCE OF (c) Systemic Sclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 4 years 6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1981 19 84 to 10/27 19 84 , that (I) (we) lost saw the deceased alive on 10/20 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jonathan M. Adelson MD		DEGREE MD		22c. DATE SIGNED 10/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan M. Adelson MD		22e. ADDRESS 5806 Baltimore Ave Hyattsville, MD 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE Oct. 30, 1984	23c. NAME OF CEMETERY OR CREMATORY Uniformed Services University of the Health Sciences, Bethesda, MD	23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA		25a. DATE REC'D. BY REGISTRAR NOV 2 1984		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall	

BP

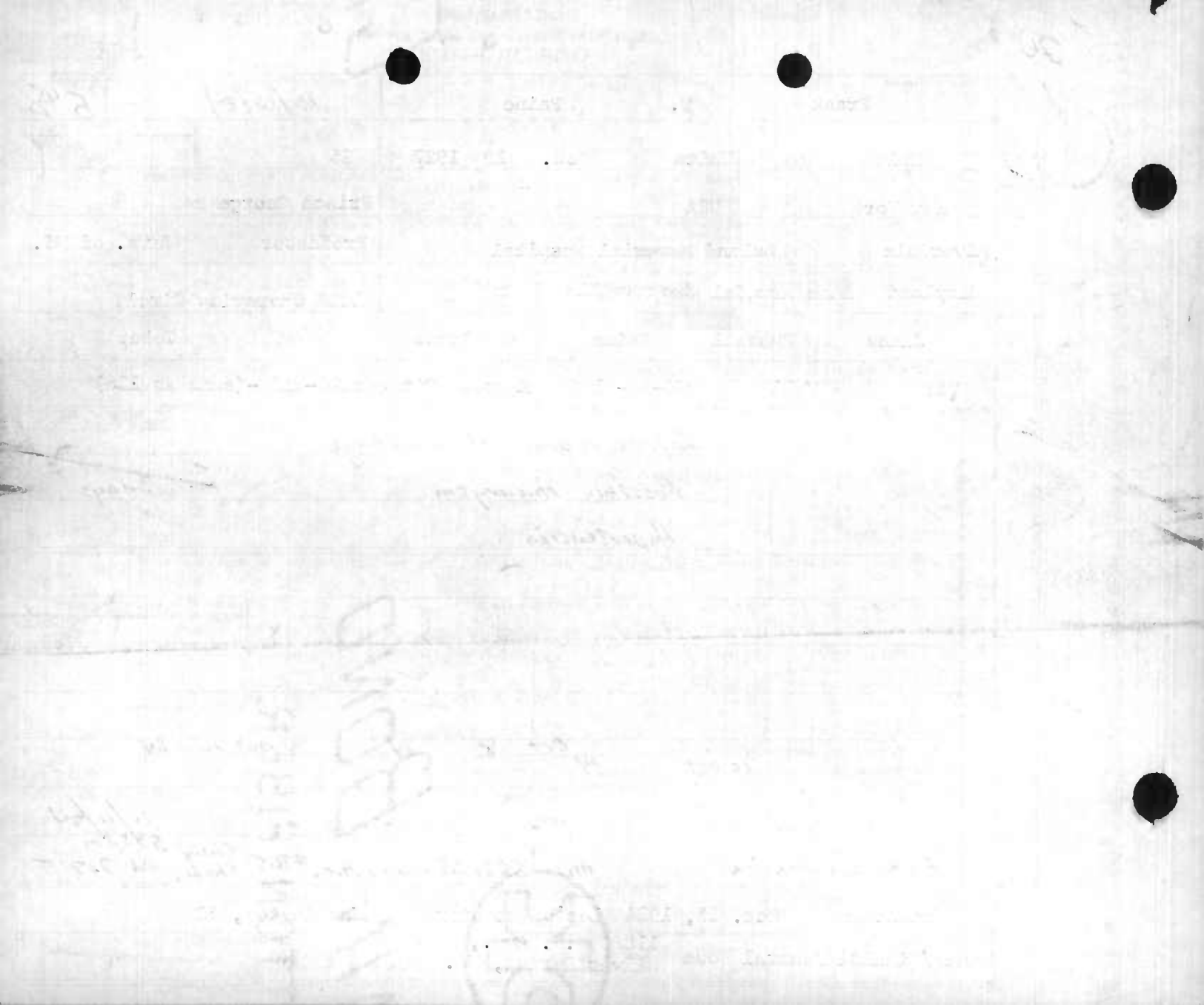


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Frank T. Paine				2a. DATE OF DEATH 10/10/84			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 19 1927		2b. HOUR 5:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) 56		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		12b. KIND OF BUSINESS OR INDUSTRY Univ. of Md.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN Anne Arundel 13c. COUNTY Crownsville				13d. INSIDE CITY LIMITS? YES NO			
14. FATHER'S NAME James Russell Paine				15. MOTHER'S MAIDEN NAME Grace Tobey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES (IF YES, GIVE YEAR OR DATES) WWII				16b. SOCIAL SECURITY NO. 090-20-6198			
17. INFORMANT Maureen Fitzgerald-wife-(same as 13e)				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Possible Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 8, 19 84 , to Oct 10, 19 84 , that (I) (we) lost saw the deceased alive on 10 Oct 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. N. Boourian				DEGREE MD		22c. DATE SIGNED 10/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. N. BOOURIAN				22e. ADDRESS MO 5530 Wisconsin Ave. #805 Chevy Chase, Md 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR OCT 11 1984			
11800 N.H. Ave., Silver Spring, Md.				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Manuel A. Parvis, III						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 10-7 1984		2b. HOUR 5:15 p.			
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 1, 1954	6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 10-7 1984					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.					
10. CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5757 Old Temple Hills Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer (Steam)		12b. KIND OF BUSINESS OR INDUSTRY Construction			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George's 13c. CITY OR TOWN Ft. Washington						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3101 Crafford Drive, #518			
14. FATHER'S NAME FIRST MIDDLE LAST Manuel A. Parvis, Jr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jame M. Klimkiewicz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 215-62-9281		17. ADDRESS Cari Ann Parvis - Same As #13 A-E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10-7 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in auto		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5757 Old Temple Hills Rd., Temple Hills, Prince George's Co., Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 10-8-84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE October 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Maryland			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE <i>P. Davidson</i>					
6638 Old Alexander Ferry Road, Clinton, Maryland											

BP

DHMH - 17
(VR A15 ME)
20M 4/B2

STANDARD FORM NO. 64



UNITED STATES



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			20. DATE KNOWN OF DEATH			21. DATE OF DEATH			22. DATE OF DEATH		
FIRST MARY			MIDDLE PATTERSON			LAST PATTERSON			20. DATE KNOWN OF DEATH 16 MONTH DAY YEAR 1984		
3. SEX F			4. RACE W			5. DATE OF BIRTH 13/11/1927			6. AGE (IN YEARS) 57		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges Gen'l. Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. STATE Md			13b. COUNTY Prince Georges			13c. CITY OR TOWN St. Plessum			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME William Robinson			15. MOTHER'S MAIDEN NAME Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 240-12-0988		
17. INFORMANT Juanita Wilson			ADDRESS 5100 S. 13 E			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 id.											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER			DATE SIGNED 10/17/84		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS 1919 Seminary Rd. Maryland			23a. BURIAL, CREMATION, REMOVAL			23b. DATE 10-20-84		
23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery			23d. LOCATION CITY OR TOWN P. O. Box			23e. COUNTY P.G. MD			23f. STATE		
24. FUNERAL DIRECTOR NAME H.S. Washington			ADDRESS 4925 Bunnings Ave N.E			25a. DATE REC'D. BY REGISTRAR 10/25/84			25b. REGISTRAR'S SIGNATURE John Davidson		



QNDP

92817

QNDP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) MICHELLE MARIE PAZ						2a DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> Oct 22 1984					
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH Sept DAY 7 YEAR 1968		6 AGE (IN YEARS) LAST BIRTHDAY 16 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10 CITY OR TOWN OF DEATH Bowie			11 HOME ADDRESS (TYPE STREET ADDRESS) 1303 Port Echo Lane			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never worked			12b KIND OF BUSINESS OR INDUSTRY N/A		
13a STATE Maryland				13b COUNTY Prince George's		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 1303 Port Echo Lane 20716	
14 FATHER'S NAME FIRST Juan MIDDLE A. LAST Paz				15 MOTHER'S MAIDEN NAME FIRST Iliana MIDDLE C. LAST Canas							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT Juan A. Paz ADDRESS 1303 Port Echo Lane Bowie, Maryland 20716					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive Disorder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None											
19a DATE OF OPERATION None				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) Dep.			DATE SIGNED Oct 22 1984		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M. D.						ADDRESS 1919 Seminary Road Sil. Spr., MD 20910					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE October 25, 1984		23c NAME OF CEMETERY OR CREMATORY Resurrection Cemetery			23d LOCATION CITY OR TOWN Clinton, Prince George's STATE MD			
24 FUNERAL DIRECTOR NAME Keith H. Klatt						25a DATE REC'D. BY REGISTRAR OCT 25 1984			25b REGISTRAR'S SIGNATURE [Signature]		
24 FUNERAL HOME Beall Funeral Home						25a ADDRESS 6000 Annapolis Road Bowie, Maryland 20715					

MEDICAL CERTIFICATION

1

1903 FORT BEND LANE

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
RICHARD E PERKINS		10 11 84		11:14 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	MONTH DAY YEAR	65	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Wash., D.C.	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON	Southern Md Hospital		Carpenter - Ret.	Construction	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland		Prince George	Suitland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2523 Shadyside Avenue 20746
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Francis Perkins		Georgianna King			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS		
Yes		WWII	P.O. Box 15 Callao, Virginia		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)		cardio-pulmonary arrest			
DUE TO, OR AS A CONSEQUENCE OF					
(b)		septic shock			
DUE TO, OR AS A CONSEQUENCE OF					
(c)		Acute hepato-renal failure			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Pneumonia, Lactic acidosis, Acute upper G.I. bleeding, chronic ethanol abuse					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 10/10, 19 84, to 10/11, 19 84, that (I) (we) last saw the deceased alive on 10/11, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
MAHESH CHANDRA		M.D.		10.12.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MAHESH CHANDRA		9131 PISCATAWAY RD., CLINTON, MD 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/15/84	St. Barnabas Epis. Ch. Cen.	Oxon Hill P.G. Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George P. Kalas Funeral Home		Oxon Hill, Md.		OCT 15 1984 Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

George F. Kalar Funeral Home Oxon Hill, Md.
 6150 Oxon Hill Rd.
 St. Barnabas Epia. Ch. Cem. Oxon Hill F.G. Maryland
 Burial 10/1-84

Yes Will 579-09-8612 Frank Perkins
 Perkins
 P.O. Box 15
 Collins, Virginia

Francis
 Perkins
 Georgia
 King

Maryland Prince George
 2523 Shady Side Avenue
 20716
 Carpenter - Ret. Construction

Wash., D.C. U.S.A.
 x
 Male Caucasian Sep. 15 1919 62

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA E. PERNA			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 27, 1984		2b. HOUR 11:50 a				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 3, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) beautician		12b. KIND OF BUSINESS OR INDUSTRY beauty salon		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY PG		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8408 Snowden Loop Ct 20708	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Obuchowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Begowich						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 046 26 5296		17. INFORMANT Kenneth Catino same as above			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COMA DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/13, 1984, to 10/27, 1984, that (I) (we) lost saw the deceased alive on 10/27, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Luis A. Heffess MD				DEGREE		22c. DATE SIGNED 10/28/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis A. Heffess	
22e. ADDRESS 9811 MALLARD DR LAUREL 20708									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 31, 1984		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Springdale, Connecticut			
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE OCT 31			

15 84 35 60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR			
FRANCIS R. PHILLIPS				10/22 1984				84			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE [IN YEARS (LAST BIRTHDAY)]	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		7d. HOUR		7e. MIN	
Male	White	12 21 05	78 YRS.			10 23 1984		12:08		a. m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		USA				Prince George MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Suitland		2914 Sunset Lane				Retired Inspector		D.C. Gov't.			
13a. STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Pr. George		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2914 Sunset Lape 20746			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John E. Phillips				Jesse Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				578-01-1443		Nora P. Phillips same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED					
Augusto P. Rodriguez		Deputy				10/23/1984					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Camp Springs, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE	
Burial		10/26/84		Ft. Lincoln Cemetery		Brentwood				Md.	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.						OCT 25 1984		Julia Davidson-Randall			

12:10

Washington, D.C. USA
Retired Inspector U.S. Gov't.
John Phillips
Mr. George Phillips
Retired Inspector U.S. Gov't.
James Phillips

U.S. Office of the Attorney General
Washington, D.C.
10/25/61
U.S. Office of the Attorney General
Washington, D.C.
10/25/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the regularly death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28467

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
ANNIE D PILKERTON		10 24 84 2:46 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.
Female	Caucasian	August 23 1907	77
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		PRINCE GEORGES COUNTY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CLINTON MD	SOUTHERN MARYLAND HOSPITAL	Housewife	N/A
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. STREET ADDRESS / ZIP CODE
Maryland	Prince George	Ft. Washington	7600 Allentown Rd. 20744
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Thomas J. Stone	Mary Marr		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No	214-48-7590	Mary Esther Walter Rte. 1, Box 336 White Plains, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY.			
IMMEDIATE CAUSE (a) <u>Acute Infarct / Anterior Myocardial</u>			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Atherosclerosis</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	
		19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/24/84</u> 19 <u>84</u> to <u>10/24</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/24</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)			
22b. SIGNATURE		22c. DATE SIGNED	
<u>George P. Kalas</u>		<u>10/24/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
<u>George P. Kalas</u>		<u>Waldorf Rd 20607</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		10/27/84	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Washington Nat'l. Cem.		Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
George P. Kalas Funeral Home		OCT 26 1984	
46160 Oxon Hill Rd. Oxon Hill, Md.		25b. REGISTRAR'S SIGNATURE	
		<u>John A. ...</u>	

BP

George P. Kulas Funeral Home, 6100 Green Hill Rd.
 10/27/84 Washington, Md. 20711. Cent. and Land P.O. Maryland

No 21-46-7890 Mary Father Walter White Plains, Maryland
 Thomas J. Stone Mary

Maryland Prince George at Washington x 1600 Allentown, Md.
 20711

Maryland U.S.A. x
 General 23 1907 77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Barbara P. Pilkerton				2a. DATE OF DEATH MONTH DAY YEAR October 19, 1984		2b. HOUR 5:15 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 7, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hosp. of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant Assoc.		12b. KIND OF BUSINESS OR INDUSTRY Univ. of Maryland	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Pannebaker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen E. Donaldson		13e. STREET ADDRESS 12105 Myra Place 20715			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-32-6537		17. INFORMANT ADDRESS Mr. James C. Pilkerton		Address Same as No# 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE - BRAIN STEM DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cardiac Arrhythmias							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. ① Renal Failure ② Diabetes mellitus with multiple complications							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/25 19 84 to 10-19 19 84 , that (I) (we) lost saw the deceased alive on 10-19-1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Asif S. Qadri				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Oct. 21, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Asif S. Qadri, M.D.				22e. ADDRESS 4713 Berwyn Rd. College Park, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Oct 23 1984	

1. *Chlorophyll a* (Chl a) and *Chlorophyll b* (Chl b) are the two main photosynthetic pigments in green plants. They are responsible for capturing light energy and converting it into chemical energy through the process of photosynthesis. Chl a is the primary pigment, while Chl b acts as an accessory pigment, transferring energy to Chl a.

October 11, 1961

BP

DHMH - 17
(VR A15 ME (5))
20M 4 / B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)										2b. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST CLIFTON PINKETT										MONTH DAY YEAR 10-15-84	
2. SEX 4. RACE 5. DATE OF BIRTH 6. AGE (IN YEARS) 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS.										2c. DATE PRONOUNCED DEAD	
MALE BLACK OCT 4, 1941 43 YRS. MONTH DAY YEAR LAST BIRTHDAY MONTHS DAYS HOURS MIN.										MONTH DAY YEAR 10 21 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED WIDOWED NEVER MARRIED DIVORCED										9. BALTIMORE CITY OR COUNTY OF DEATH	
VIRGINIA U.S.A.										PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY											
Fort Washington 1499 Potomac Heights Drive TRUCK DRIVER TERMINAL CO.											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS											
MARYLAND PRINCE GEORGE YES NO 1499 POTOMAC HEIGHTS DRIVE											
14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME											
RANDOLPH D. PINKETT ARLILLA LYONS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT										ADDRESS	
NO 228 52 8231 CORNELL PINKETT										5380 LAURA BELLE LANE FAIRFAX, VA.	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Repetitive arterial plaque in the heart's blood vessels</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?										YES NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u> M.D. Deputy MEDICAL EXAMINER TITLE (SPECIFY) DATE SIGNED 10/21/1984											
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS 5009 Rayburn Ct., Temple Hills, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL 25OCT 84 pleasant valley mem FAIRFAX COUNTY, VIRGINIA											
24. FUNERAL DIRECTOR NAME 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
GREENE FUNERAL HOME, INC. 814 FRANKLIN STREET ALEXANDRIA, VIRGINIA 22304 OCT 29 1984											

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

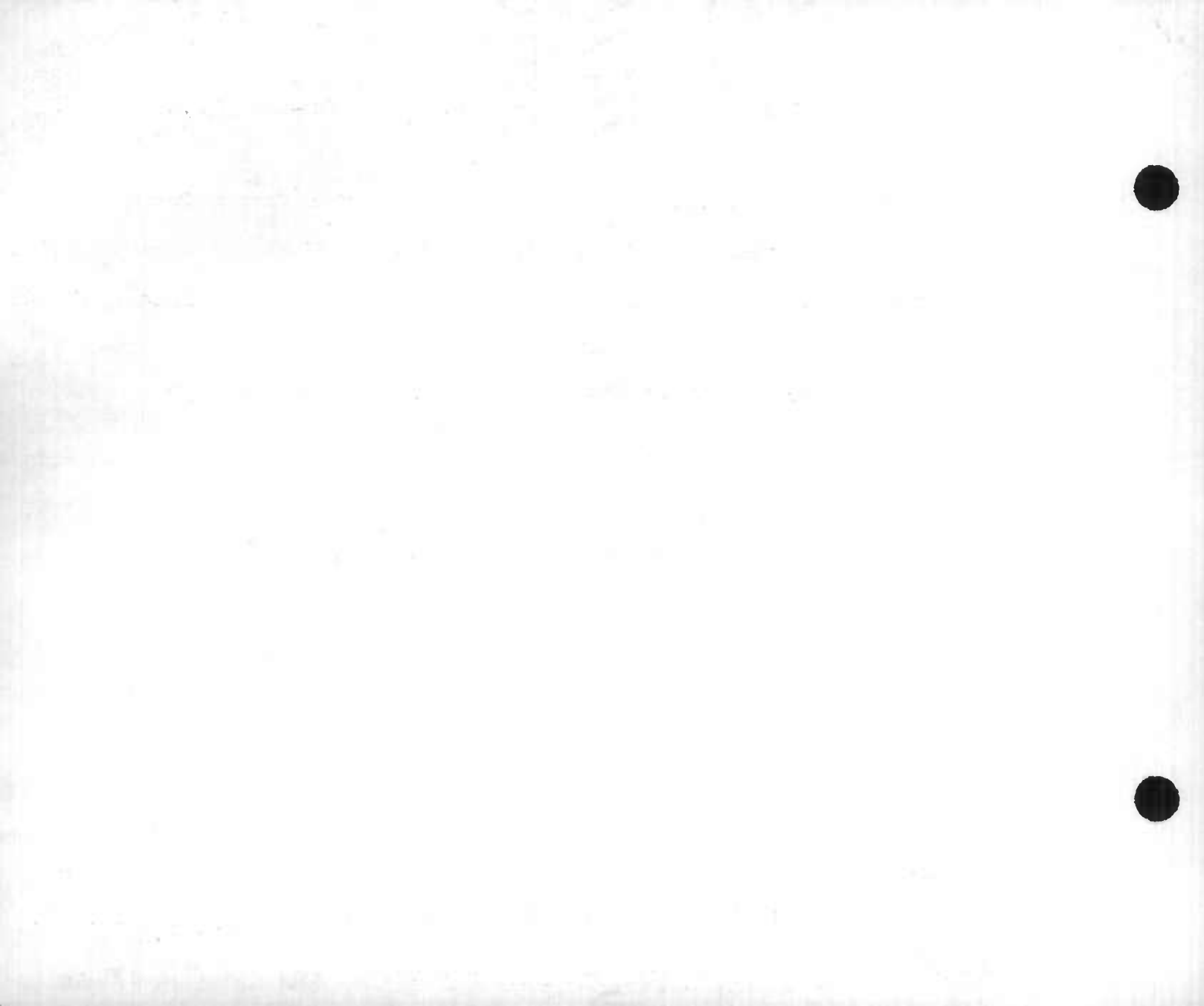
2 8 4 7 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Edward Poe Jr.			2a. DATE OF DEATH MONTH DAY YEAR October 30, 1984		2b. HOUR 7:04P M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 18, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY Heavy Equip.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10406 Scaggsville Rd. 20707	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edward Poe Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Green							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Ramona M. Poe		ADDRESS same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebrovascular accident / Myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Infection / Coronary Artery Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Ali Baig</i>			DEGREE			22c. DATE SIGNED 10-31-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ali Baig			22e. ADDRESS 14201 Laurel Ave. 20707							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/2/84		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A. Co. Md.			
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel 1, Md. 20707					25a. DATE REC'D. BY REGISTRAR NOV 2 1984		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson</i>			

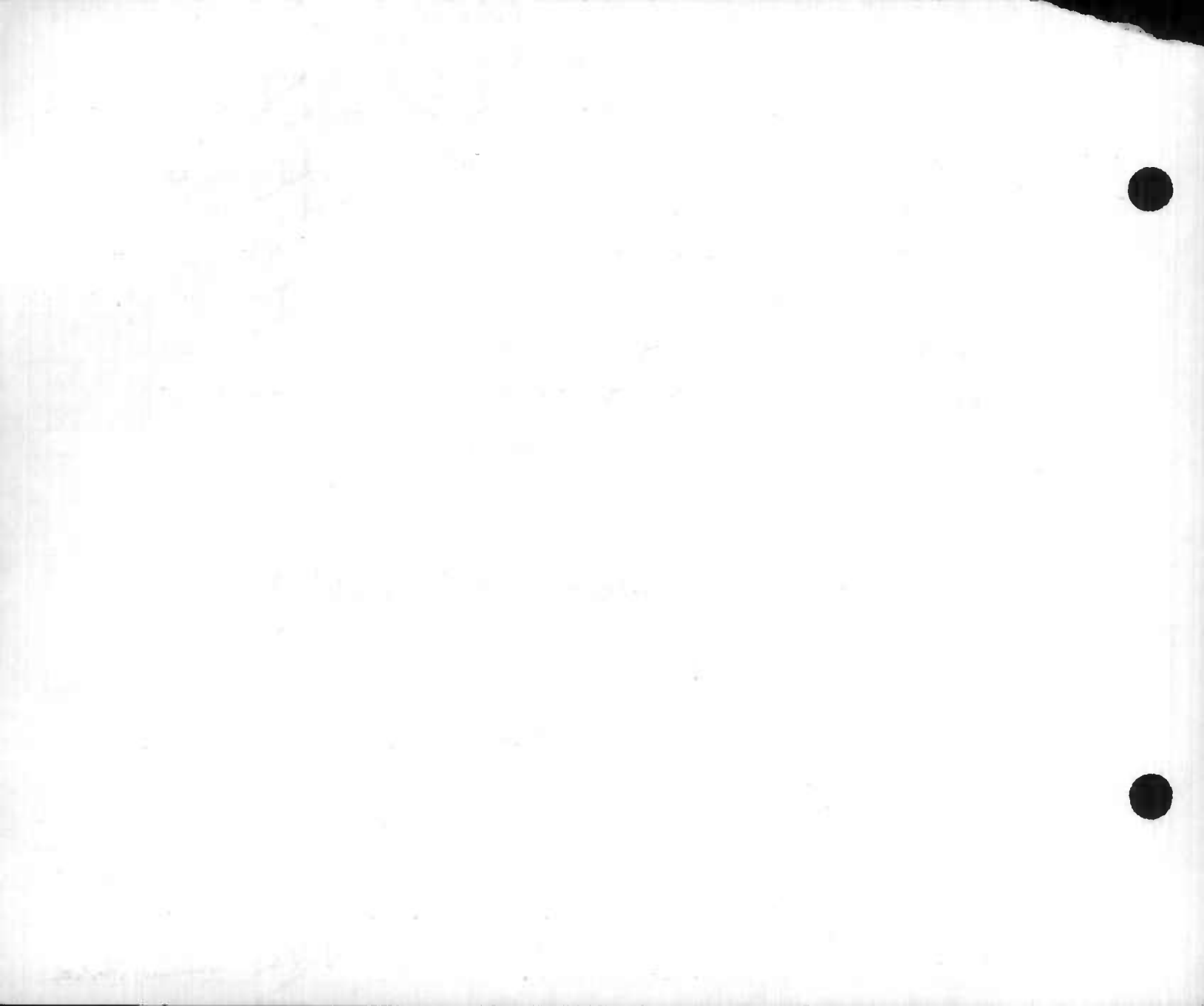
BP.



2 8 4 7 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Vincent J. Pokorney		MONTH DAY YEAR October 20, 1984	
3. SEX		7b. HOUR	
Male		9:50A M	
4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	
Caucasian	MONTH DAY YEAR April 7 1899	85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland	U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Laurel	Greater Laurel Beltsville Hospital	Carpenter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE
Maryland	Howard	Savage	Savage Guilford Rd. 8398 20863
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Jacob Pokorney	Anna Anna Hrach		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)	17. INFORMANT ADDRESS	
No	N/A	Marie Pokorney Same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Oat cell carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Disseminated intervascular coagulation PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/19 , 19 84 , to 10/20 , 19 84 , that (I) (we) last saw the deceased alive on 10/19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.			
22b. SIGNATURE Gregory A. Compton MD		22c. DATE SIGNED 10/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A. COMPTON MD		22e. ADDRESS 4201 LAUREL PARK DR #221 LAUREL, MD 20707	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	10/23/84	Meadowridge Mem.Pk.	Baltimore, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REGD. BY REGISTRAR	
FLECK FUNERAL HOME INC. 7601 Sandy Spring Rd. Laurel, Md.		OCT 24 1984	
		25b. REGISTRAR'S SIGNATURE Davidson-Randall	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR			
TREVIN POLLARD				DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10 6 19 84				2b. HOUR 12:00 a.m.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD				2d. HOUR	
MALE	BLACK	JUNE 21 1967	17 YRS.	MONTHS	DAYS	10 6 19 84				12:00 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WASHINGTON D.C.		U.S.A.				Prince George's County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp.				STUDENT		NONE			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		PRINCE GEORGES		CAPITOL HGTS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1423 ELKWOOD LANE 20743			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
CLARENCE F POLLARD				BARBARA REYNOLDS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				UNK		CLARENCE POLLARD 1423 ELKWOOD LANE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Gunshot wound to chest (handgun)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
11:20xx 10-5- 1984				HOUR A.M. MONTH DAY YEAR		Subject was shot.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
				street		1423 Elkwood Lane, Fairmont Heights, Prince George's, Md					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Ann M. Dixon, M.D.				M.D. Assistant MEDICAL EXAMINER				10-6-84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
				111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				10/12/84		HARMONY MEMORIAL PARK		LANDOVER MARYLAND			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			
J.B. JENKINS FUNERAL HOME				7474 LANDOVER RD				OCT 15 1984			
								25b. REGISTRAR'S SIGNATURE			
								Ann M. Dixon			

[Faint, mostly illegible text covering the majority of the page, possibly a memorandum or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

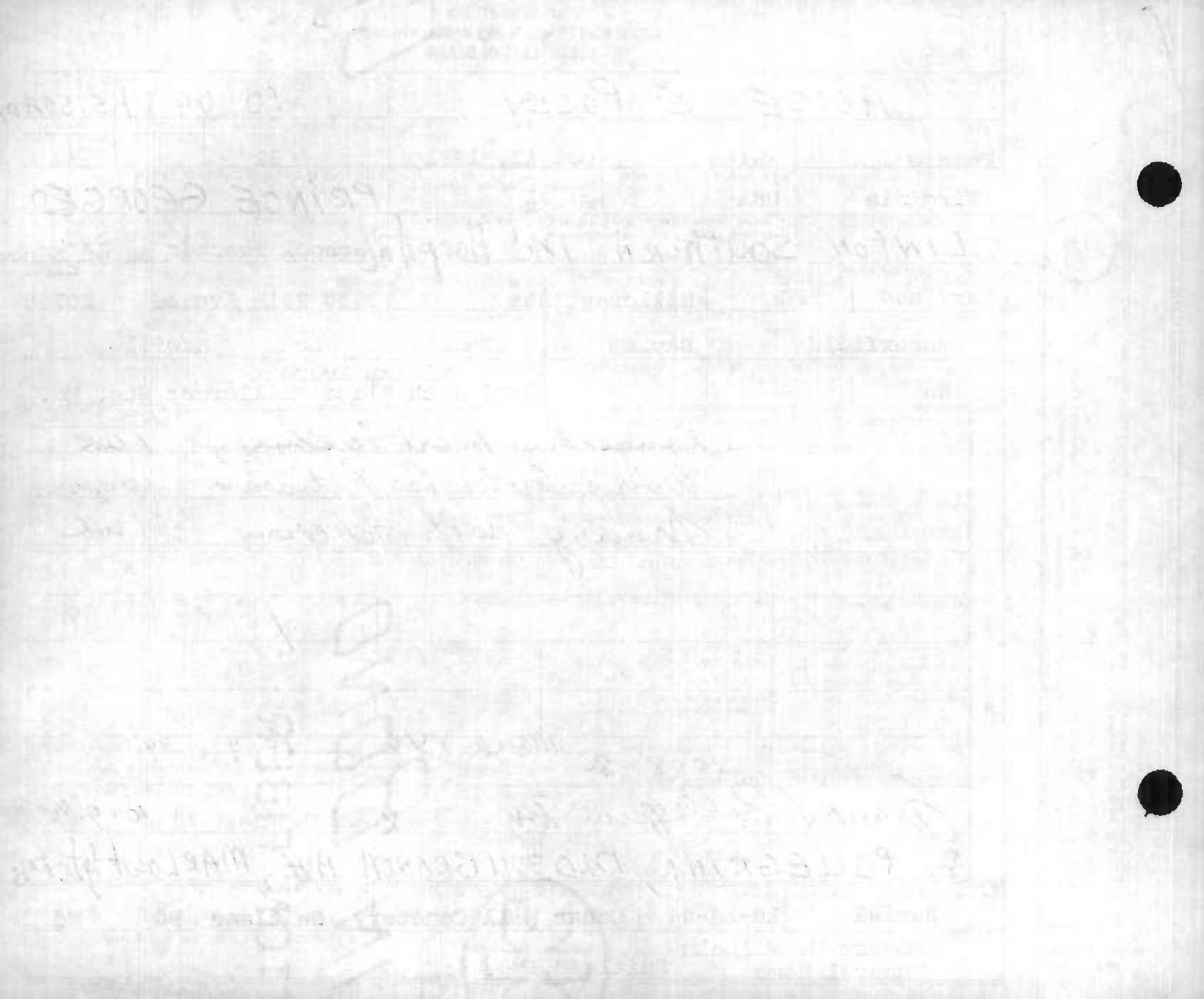
2 8 4 7 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALICE E POSEY			2a. DATE OF DEATH MONTH DAY YEAR 10 09 84			2b. HOUR 5:50AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 12, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY D. C. Education	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Hillcrest Hts		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 3520 29th Avenue 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Dangerfield Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Lou Atwill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS Miriam Everett 3509 29th Place Hillcrest Hts. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 10 yr 1 wk	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from March 19 86 , to 10.9.84 , that (I) (we) last saw the deceased alive on 10.8.84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frank Pellegrini						DEGREE MD		22c. DATE SIGNED 10.9.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. PELLEGRINI						22e. ADDRESS 3611 BRANCH AVE, MARLOW Hts. Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-10-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John Davidson	
Funeral Home						Suitland, Md.			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28474			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZEL D. POTTER				2a. DATE OF DEATH MONTH DAY YEAR 10-07-84			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR December 26, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hurlock, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Acme Markets		12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest B. Spry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ollie Cephas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165-12-1211		17. INFORMANT ADDRESS 21643 Lena M. Houg, P.O. Box 51, Hurlock, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anoxic encephalopathy</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13/84</u> 19 <u>84</u> to <u>10/7/84</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/7/84</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (TYPE OR PRINT) M. GHOSH M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 10/7/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Nr Hurlock, Dorchester, Md.	
24. FUNERAL DIRECTOR NAME Frankston Hauris				25a. DATE REC'D. BY REGISTRAR 2635 OCT 16 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
JUL 1 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28475

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rexford — Powell			2a. DATE OF DEATH MONTH DAY YEAR 10 20 84		2b. HOUR 8 30 P M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 24 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.		
10. CITY OR TOWN OF DEATH ADELPHI	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8903 RIGGS ROAD 20783		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTOMOBILE MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.			13b. COUNTY PR. GEO	13c. CITY OR TOWN ADELPHI	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN POWELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-203-051		17. INFORMANT ADDRESS HELEN A. POWELL, 8903 RIGGS RD ADELPHI 20783	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/28/78, 19 to 10/20, 1984, that (I) (we) last saw the deceased alive on Sept 19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Smith S. Ho M.D.		DEGREE		22c. DATE SIGNED 10/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH S. HO M.D.		22e. ADDRESS 4610 Carroll Ave Takoma Park Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE OCT. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY George Washington	
23d. LOCATION (CITY OR TOWN) Riggs Road, F.G. Co.		23e. COUNTY Md.		23f. STATE	
24. MEDICAL DIRECTOR J. Edgar Walters		25a. DATE REC'D. BY REGISTRAR OCT 24 1984		25b. REGISTRAR'S SIGNATURE John Davidson	
25c. ADDRESS 254 Carroll St. N. W. D. C.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. FOR STATE REGISTRAR					2. DATE OF DEATH MONTH DAY YEAR					7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD O. PRITCHARD					10-07-84					10 06PM	
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05-06-04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY PAINTING			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Md. ST. MARY'S CROWNSTOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 56 SUMMERHILL PARK 21032				
14. FATHER'S NAME FIRST MIDDLE LAST JOHN OAKLEY PRITCHARD					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-10-0597		17. INFORMANT ADDRESS HOWARD W. PRITCHARD (SAME AS #13)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antero-Septal Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Functional Abdominal Obstruction, COPD</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (a) (this hospital) attended the deceased from <u>OCT 6</u> 19 <u>84</u> , to <u>OCT 7</u> 19 <u>84</u> , that (b) (we) saw the deceased alive on <u>OCT 7</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Stuart Turkewitz</u> M.D. DEGREE					22c. DATE SIGNED 10-8-1984						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Turkewitz, M.D.					22e. ADDRESS 7500 Greenway Ctr. Dr. #420 Greenbelt, Md. 20770						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE OCT 15, 1984		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G. Md.					
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS Co.					25. DATE REC'D. BY REGISTRAR OCT 11 1984						
26. REGISTRAR'S SIGNATURE J. Davidson											

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 477

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucy B. Pritchard			2a. DATE OF DEATH MONTH DAY YEAR October 29, 1984		2b. HOUR 12:59A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 24, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Ohio			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13c. CITY OR TOWN, COUNTY Cuyahoga Rocky River			13d. STREET ADDRESS / ZIP CODE 3829 E. Surrey 94099 44115		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Ripple		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily Straley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.		16b. SOCIAL SECURITY NO. 232-62-3732		17. INFORMANT ADDRESS Robert S. Pritchard same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

one week

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Lymphocytic Leukemia

3 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 18 19 84, to Oct 29 19 84, that (I) (we) last saw the deceased alive on Oct 28 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE B. W. Gattus	DEGREE MD	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE W. GATTUS	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. ADDRESS 14333 LAUREL-BOWIE RD. #200 LAUREL, MARYLAND 2070P	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/1/84	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	23d. LOCATION Brookpark, Cuyahoga, Ohio
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707		25a. DATE REC'D. BY REGISTRAR OCT 30 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1- FOR STATE REGISTRAR				2a DATE OF DEATH MONTH DAY YEAR 2b HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARENCE A. PROCTOR				10-06-84 11:10PM			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 2 92		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 92	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY P.G. 13c. CITY OR TOWN Seat Pleasant				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 7030 Canyon Drive 20743			
14. FATHER'S NAME FIRST MIDDLE LAST Benny Proctor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-14-8643		17 INFORMANT ADDRESS Dorothy Pinkney 7030 Canyon Drive Seat Pleasant MD 20743		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO - PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREbro - VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 09-26 19 84, to 10-06 19 84, that (I) (we) last saw the deceased alive on 10-06 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10-9-84.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] (VELLANKI)				22e. ADDRESS Prince George's General Hospital Cheverly			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/11/84		23c. NAME OF CEMETERY OR CREMATORY Shiloh Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wayside Charles County MD	
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019				25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE [Signature]	



WASHINGTON, D.C. 20013
4332 HUNT PLACE, N.E.
ROLLING FURNACE HOME, INC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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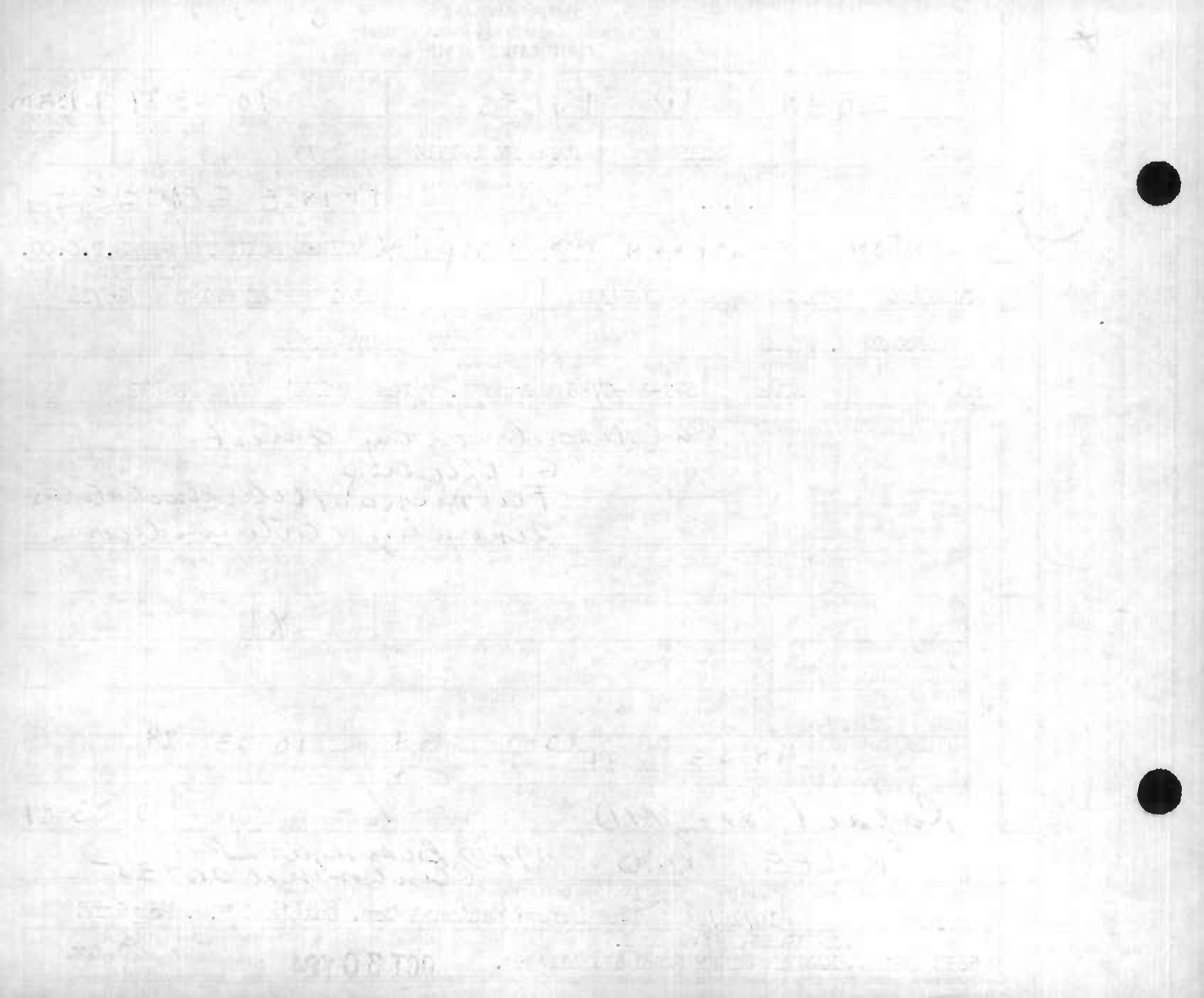
IMPORTANT: If item 21 is marked or item 18 checked, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 7 9

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN W PYLES		2a. DATE OF DEATH MONTH DAY YEAR 10 23 84	
3. SEX MALE		4. RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR JANUARY 2, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED BUILDING		12b. KIND OF BUSINESS OR INDUSTRY SUPER. P.G.CO.	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGES CLINTON	
13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 6301 DENLEE DRIVE 20735		13f. SCHOOLS	
14. FATHER'S NAME FIRST MIDDLE LAST FRANKLIN W. PYLES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA GLADYS ESTES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-14-6786	
17. INFORMANT ADDRESS Anna L. Pyles (Wife) SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>G.I. Bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fat embolism</u> DUE TO, OR AS A CONSEQUENCE OF <u>Generalized enterovirus</u> (c) <u>Generalized enterovirus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>84</u> , to <u>10-23</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10-23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Rafael C. Lee MD		22c. DATE SIGNED 10-23-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. LEE M.D.		22e. ADDRESS 9410 Brandywine Rd Clinton Md 20735	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/84	
23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME INC.		25a. DATE REC'D. BY REGISTRAR OCT 30 1984	
6633 OLD ALEXANDER FERRY ROAD CLINTON MD.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Lake Edward Ransom			10 26 19 84			10:47 a					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			7d. HOUR		
Male	Cauc.	12-16-15	68 YRS.			10 26 19 84			10:47 a		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			USA						Prince George's County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's General Hospital			Onwer/Self-Emp.			Auto Part		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			P.G.			Upper Marlboro			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
Joseph Jayhue Ransom			Annie Lou Goode			No			577-20-4827		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Nancy J. Ransom, same as line 13						PART I DEATH WAS CAUSED BY:					
						IMMEDIATE CAUSE (a) Multiple injuries					
						DUE TO, OR AS A CONSEQUENCE OF					
						(b)					
						DUE TO, OR AS A CONSEQUENCE OF					
						(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			9:45xx 10 26 19 84			Drifting truck pinned subject to tree					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
			junk yard			11542 Old Marlboro Pike, Upper Marlboro, P.G., MD					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			TITLE (SPECIFY)						DATE SIGNED		
Thomas D. Smith, M.D.			Deputy Chief						10/27/84		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
Thomas D. Smith, M.D.			111 Penn St. BALTO., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			10-29-84			St. Paul's Cemetery			Baden, P.G., Maryland		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Huntt Funeral Home, Waldorf, Maryland			OCT 30 1984			John H. Harker - Pendall					

MEDICAL CERTIFICATION



Walt Jones 27-11-12 28

Walt Jones

Walt Jones

Walt Jones

Walt Jones 27-11-12 28

Walt Jones 27-11-12 28

Walt Jones 27-11-12 28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Margaret B. Remson				2a. DATE OF DEATH MONTH DAY YEAR September 20, 1984		2b. HOUR 9:30 P.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 26 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teller		12b. KIND OF BUSINESS OR INDUSTRY Bank	
13a. STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry N. Ball				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marabel M. Shepard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-07-3739		17. INFORMANT ADDRESS 7612 Kidmore Lane Norris M. Rensom, Son Lanham, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis, Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Aneurysm PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ()							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 13, 1984 , to Sept. 20, 1984 , that (I) (we) last saw the deceased alive on Sept. 10, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Brian S. Bayly</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian S. Bayly, M.D.				22e. ADDRESS 5901 Medical Terrace, Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Francis Gaschs Sons, P.A. Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR OCT 16 1984			
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

BP

[illegible]

38011

George, Royal Engineer

10/11/1961

4

10/12/24

X

Mr. J. H. ...

1. The first of these is the fact that the

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Alice Naomi RICHARDS			2a. DATE OF DEATH MONTH DAY YEAR October 3, 1984			2b. HOUR 4:09 AM			
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 1-4-1926		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 15103 Croom Road, 20613	
14 FATHER'S NAME FIRST MIDDLE LAST Percy Allen Hall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Annette Boswell					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-24-0325		17 INFORMANT (Spouse) ADDRESS Frank S. Richards, Sr. Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RHEUMATIC HEART DISEASE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>9-50-</u> 19 <u>84</u> to <u>10-3</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10-2-</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b PHYSICIAN'S NAME (TYPE OR PRINT) M.H. CHAUDHARY MD						22c ADDRESS 14201 Laurel Rd Prince Georges County Md. 20707		22e DATE SIGNED 10-3-84	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-5-84		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Church		23d LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.			
24 FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Md.						25 DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 8 1984 Julia Davidson			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with item 72 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EDNA E. ROBINSON				2a. DATE OF DEATH MONTH DAY YEAR 10-02-84		2b. HOUR 10:50 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Waldorf	
14. FATHER'S NAME FIRST MIDDLE LAST William Dotson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sewell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-54-8746		17. INFORMANT Nelson Robinson		ADDRESS SAA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypoxemia Encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus Chronic Renal Failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>10/2/1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jaswinder Sidhu</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASWINDER SIDHU, M.D.				22e. ADDRESS 4700 AUTH RD. CAMP SPRINGS, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-6-84		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Ch		23d. LOCATION CITY OR TOWN COUNTY STATE Brandywine P.G. Md	
24. FUNERAL DIRECTOR NAME ADAMS F.H. PA AQUASCO MARYLAND 20608				25. DATE REC'D. BY REGISTRAR OCT 10 1984			
				25b. REGISTRAR'S SIGNATURE John Davidson-Rendell			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST <i>Charles</i>	MIDDLE <i>Lee</i>	LAST <i>Rohrer</i>	MONTH DAY YEAR <i>10 12 '84</i>			8:45P _M		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 9 98</i>		6. AGE [IN YEARS LAST BIRTHDAY] <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) <i>U.S.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Price Georges</i> MD.			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>7600 Carroll Ave Takoma Park</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Meat Cutter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>md</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Boonsboro</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Elmer J. Rohrer</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cora Clopper</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <i>No</i>			16b. SOCIAL SECURITY NO. <i>219-05-4719</i>		17. INFORMANT <i>15206 Ingleside Dr. Wilmer A. Rohrer, Beltsville, Md. 20705</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

BRAIN METASTASIS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) *CARCINOMA OF STOMACH*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/13</i> , 19 <i>84</i> , to <i>10/12</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>10/12</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John H. Bast, Jr.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/13/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KIRKLAND C. BRACE</i>				22e. ADDRESS <i>7600 CARROLL AVE, TAKOMA PARK, MD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>10-15-84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rohrersville Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rohrersville, Wash. Co., Md.</i>
24. FUNERAL DIRECTOR NAME <i>John H. Bast, Jr.</i>		ADDRESS <i>Boonsboro, Md. 21713</i>	25a. DATE REC'D. BY REGISTRAR <i>OCT 17 1984</i>
			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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2010-01-01

East Valley Grocery

broccoli, corn, etc.

13000

Belleville, Mo. 63015

15-21-01

... ..

John H. Bates, Jr. December 22, 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

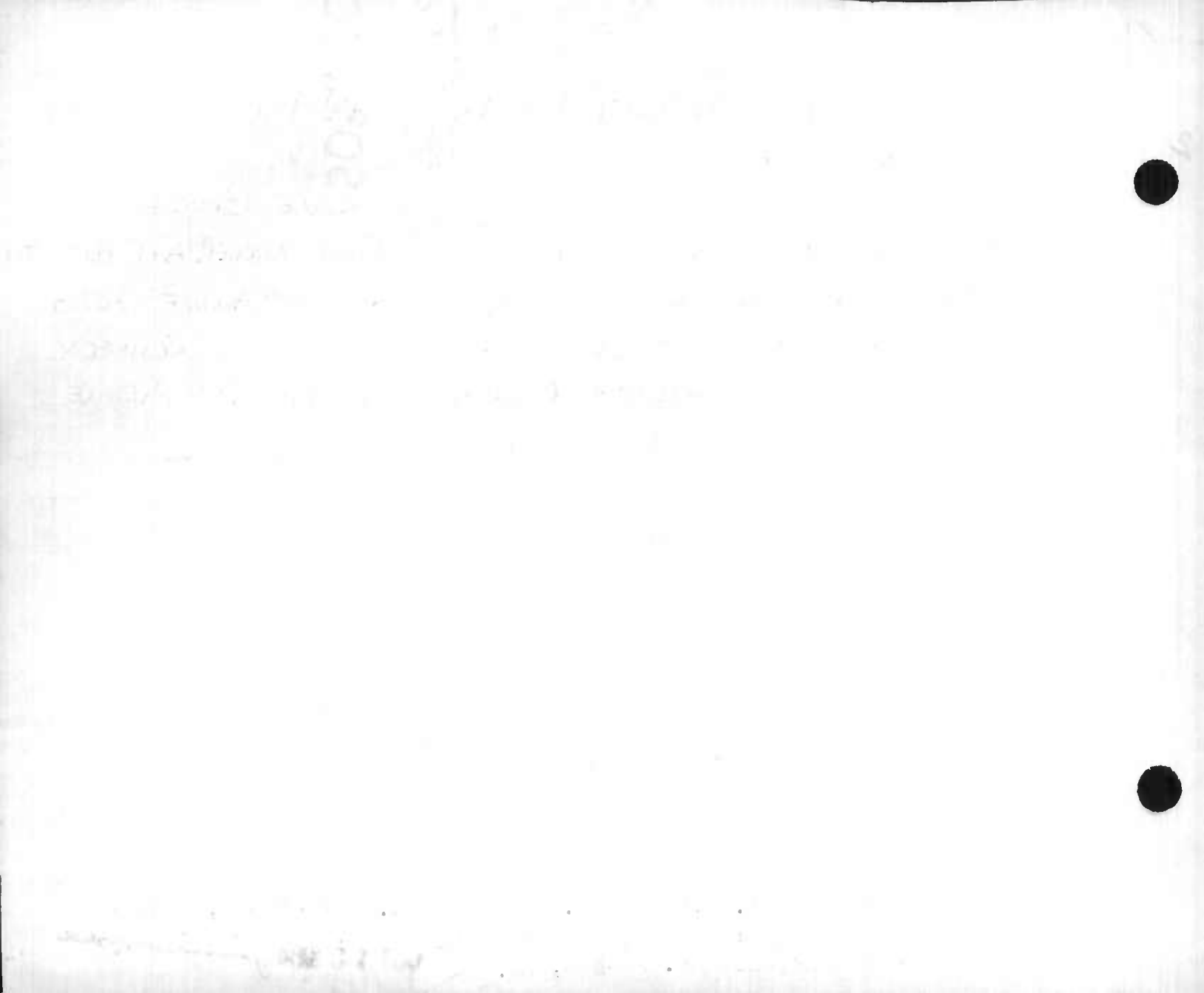
IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES RANDOLPH RUDD			2a. DATE OF DEATH MONTH DAY YEAR 10/10/84			2b. HOUR 4 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 8 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH W. LANHAM HILLS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4911 78th AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DELI WORKER		12b. KIND OF BUSINESS OR INDUSTRY A+P FOOD STORE	
13a. STATE MD		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN W. LANHAM HILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4911 78th AVENUE 20784	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES W. RUDD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HALLIE JOHNSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-6150		17. INFORMANT ADDRESS SADIE RUDD 4911 78th AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis hard disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 83 , to 19 84 , that (I) (we) last saw the deceased alive on 84 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. PUNSA MD				22e. ADDRESS PRINCE GEORGES GEN. HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (CITY OR TOWN) STATE Brentwood, Maryland		
24. FUNERAL DIRECTOR NAME Howard Hale's Lanham Funeral Home				25a. DATE REC'D. BY REGISTRAR OCT 16 1984		25b. REGISTRAR'S SIGNATURE [Signature]			
24. ADDRESS 9013 Annapolis Rd. Lanham, MD.									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

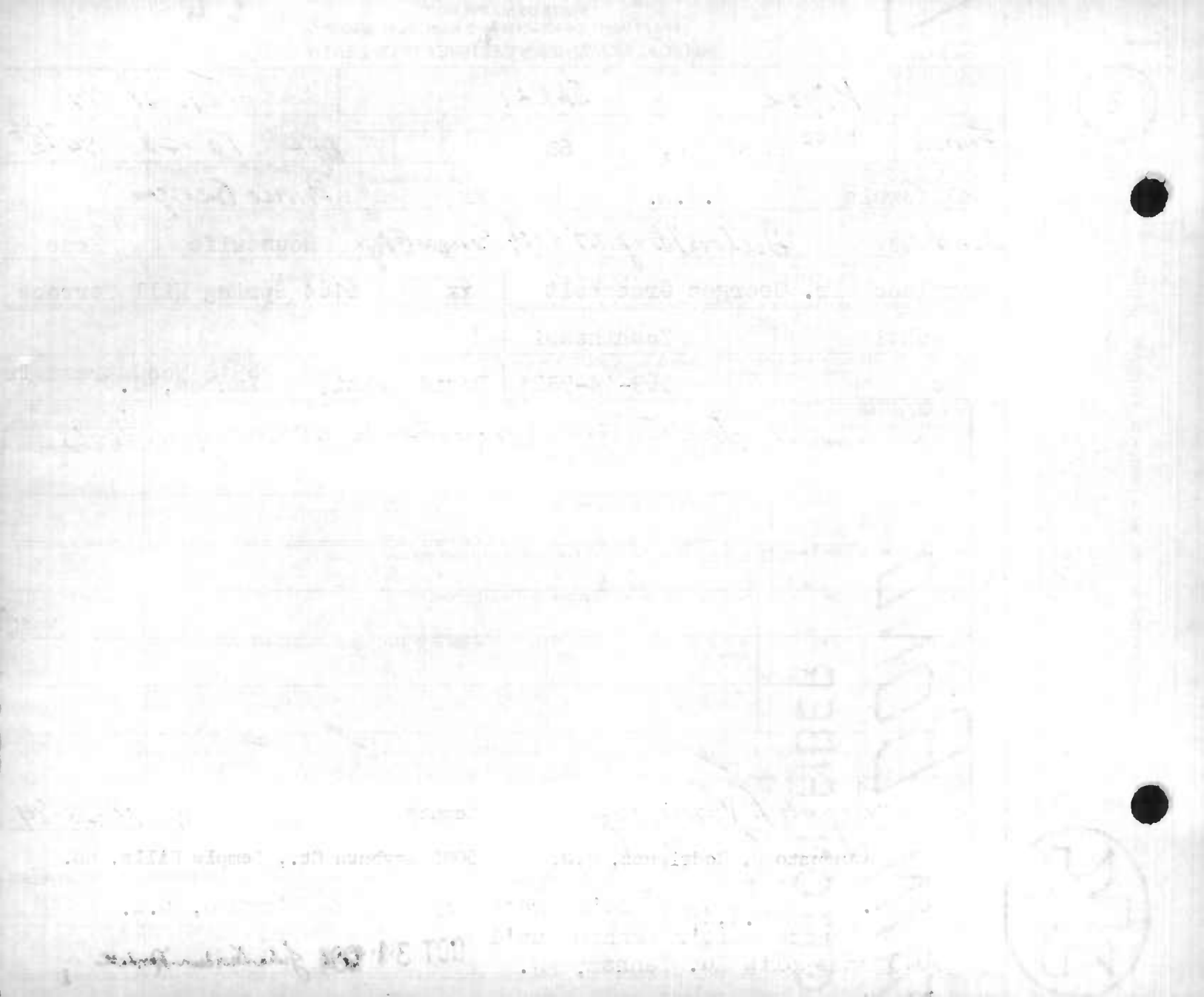
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Kiyo SAKAI</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <i>10-28 1984</i>		2b. HOUR M <i>10</i> A <i>10</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>March 26, 1916</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) <i>68</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED <i>DECEASED 10-28 1984</i>	8. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>California</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>		10. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>	
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN EACH CITY, GIVE STREET ADDRESS) <i>Doctors Hospital of H. George Co.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Pr. Georges</i>		13c. CITY OR TOWN <i>Greenbelt</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Sohei Yoshihashi</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>David Sakai</i>				16. ADDRESS <i>6918 Woodstream Tr Lanham, Md.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>569-14-9821</i>		17. INFORMANT <i>David Sakai</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic arterial atherosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>10-28-84</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Crem.</i>		23b. DATE <i>Nov. 1, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR NAME <i>Howard Hale's Lanham Fun'l H</i>		ADDRESS <i>3013 Annapolis Rd. Lanham, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 31 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Deiden</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hilary R. Sakraida			2a. DATE OF DEATH MONTH DAY YEAR 10 23 84			2b. HOUR 5 P.M.					
3. SEX Male		4. RACE African American		5. DATE OF BIRTH MONTH DAY YEAR 4 13 11		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.					
10. CITY OR TOWN OF DEATH BOWIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12618 Beechfern Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Office Manager			
13a. STATE Maryland			13b. COUNTY Pr George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12618 Beechfern Lane 20715		
14. FATHER'S NAME FIRST MIDDLE LAST John Sakraida			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wertz								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 168-104504		17. INFORMANT ADDRESS Lucille D. Sakraida 12618 Beechfern Lane Bowie, MD 20715						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c). <u>Carcinoma of Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (the hospital) attended the deceased from <u>1/11</u> , 19 <u>84</u> , to <u>10/23</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE Barry Rosenberg MD					DEGREE MD			22c. DATE SIGNED 10/23/84		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Barry Rosenberg, M.D.					22e. ADDRESS 9811 Mallard Drive, Laurel, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 26, 1984		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Church Cen.			23d. LOCATION CITY OR TOWN COUNTY STATE Bowie, Pr. George's, Maryland			
24. FUNERAL DIRECTOR NAME Beall Funeral Home					25. DATE REC'D BY REGISTRAR OCT 25 1984			26. REGISTRAR'S SIGNATURE P. Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Office Memorandum

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PM 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KIMBERLY ANN SAUCIER		2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-21-84		2d. HOUR 8	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-3-1967	6. AGE (IN YEARS) LAST BIRTHDAY 17 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Waitress	
12b. KIND OF BUSINESS OR INDUSTRY Restaurant		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1002 Sherman Court, 20601			
14. FATHER'S NAME FIRST MIDDLE LAST Richard Daniel Saucier			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn Ann Davison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-96-7951		17. INFORMANT (Mother) ADDRESS Carolyn D. Saucier, Same as line 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION 10-21-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Injuries		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Pedestrian hit by a car		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:45 P.M. 10-20-1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt 301, Waldorf, Charles, Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER DATE SIGNED 10-22/84	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-24-84		23c. NAME OF CEMETERY OR CREMATORY Washington National	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland		23e. DATE REC'D. BY REGISTRAR OCT 23 1984			
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Md.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Russell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY B. SAUNDERS			2a. DATE OF DEATH MONTH DAY YEAR 10 24 84			2b. HOUR 2:45 P M	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PGG HOSPITAL AND MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Work		12b. KIND OF BUSINESS OR INDUSTRY County	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Md. St. Mary		13c. CITY OR TOWN Maddox		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE General Delivery 20621	
14. FATHER'S NAME FIRST MIDDLE LAST Harry F. Baughman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith F. Richardson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-1681		17. INFORMANT ADDRESS Mr. Walter A. Saunders - Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:a) <u>Deep Vein Thrombosis, coronary artery disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> HOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/24/84</u> to <u>10/24</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>9/24/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Steven M. Pollak</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) POLLAK, STEVEN M.				22e. ADDRESS 4700 AUTH PLACE, CAMP SPRINGS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/25/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 31 1984	
				25b. REGISTRAR'S SIGNATURE <u>John F. ...</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					2 8 4 9 0	
1- FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HELEN N. Scanlon				2a. DATE OF DEATH MONTH DAY YEAR 10 22 84		
3. SEX FEMALE				2b. HOUR 10:07 PM		
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 6 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) COLORADO		7b. CITIZEN OF WHAT COUNTRY? American		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CLINTON				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Med. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY AT HOME				13a. STREET ADDRESS / ZIP CODE 545 Round Table Dr. 20744		
13b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY P. G. 13c. CITY OR TOWN Ft. Washington				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CHRISTIAN HANSEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE BRINKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577921926		17. INFORMANT Husband		
18. ADDRESS Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Anemia						
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-11-84 , 19 84 , to 10-22 , 19 84 , that (I) (we) lost saw the deceased alive on 10-22 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Emedita E. Quintos				22c. DATE SIGNED 10-22-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EMEDITA E. QUINTOS, M.D.				22e. ADDRESS 9548 Ft. Foote Rd., Ft. Washington, MD 20744		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/26/84		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		
23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.						
24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md				25a. DATE REC'D. BY REGISTRAR OCT 25 1984		
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

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George F. Kelly & 6160 Oxon Hill Rd. Oxon Hill, Md.

BURIAL 10/26/64 MT. OLIVET CEMETERY WASHINGTON, D.C.

PROPERTY

BRINKER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 9 1

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James W Sewell, Jr.			2a. DATE OF DEATH MONTH 10 DAY 29 YEAR 84		2b. HOUR 3:45A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Nov. DAY 14 YEAR 1900		6. AGE (IN YEARS (LAST BIRTHDAY)) 83	IF UNDER 1 YEAR MONTHS YRS. DAYS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Gov't. Worker		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Brentwood			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3404 - Tilden Street (20722)	
14. FATHER'S NAME FIRST James MIDDLE W. LAST Sewell			15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE E. LAST Kidd		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 433-09-1550		17. INFORMANT ADDRESS Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes days days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute intestinal obstruction, Acute urinary retention					
19a. DATE OF OPERATION 10/16/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute small intestinal obstruction		20a. AUTOPSY? yes YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 1982 , to 00 29 , 19 84 that (I) (was) lost saw the deceased alive on 00 28 , 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.					
22b. SIGNATURE Byrd A. Johnson		DEGREE M.D.		22c. DATE SIGNED 10/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-1-84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	
23d. LOCATION CITY OR TOWN Brentwood COUNTY Pr. Geo. STATE Md.		24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. ADDRESS Mt. Rainier, Md.			
25a. DATE REC'D. BY REGISTRAR NOV 2 1984		25b. REGISTRAR'S SIGNATURE Raymond A. Randall			

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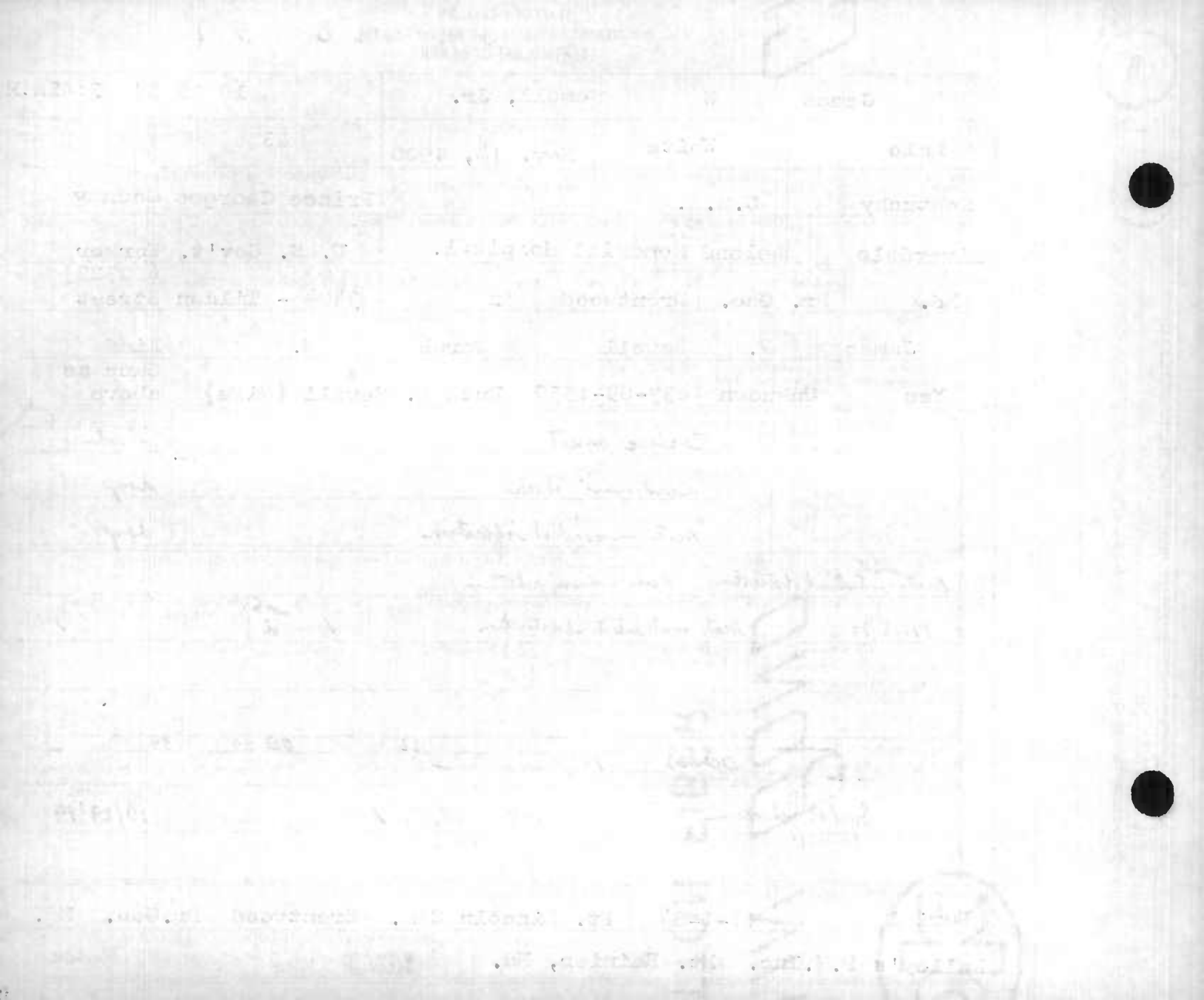
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE PLACED DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ralph J. SEWELL			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-29-84			2b. HOUR 10:29		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 / 26 / 27	6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD 10-29-84	7d. HOUR 10:29	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Malcolm Grow USAF Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photographer		12b. KIND OF BUSINESS OR INDUSTRY US GOVERN.
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE MD		13b. COUNTY PG		13c. CITY OR TOWN Dist. Hgts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 2510 Lorrington Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Sewell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
YES		WWII, Korean		Sylvia J. Sewell same as 13				
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive pulmonary disease								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy					DATE SIGNED 10-29-84	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland			23d. LOCATION CITY OR TOWN COUNTY STATE PG MD	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John E. ...		

NOV 07 1984

RECEIVED
FEB 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

Handwritten notes and stamps, mostly illegible due to fading and bleed-through. Some visible words include "FEB 10 1964" and "U.S. DEPARTMENT OF AGRICULTURE".

Handwritten notes and stamps, mostly illegible due to fading and bleed-through. Some visible words include "FEB 10 1964" and "U.S. DEPARTMENT OF AGRICULTURE".

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANET S. SHAFFER			2a. DATE OF DEATH MONTH DAY YEAR 10 10 84			2b. HOUR 12:30 AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 31 30		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		7. IF UNDER 24 HRS. HOURS MIN. 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD						
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT PLAINLY EASY, GIVE STREET ADDRESS) SOUTHERN MD HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tax Spec. IRS			12b. KIND OF BUSINESS OR INDUSTRY IRS			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD				13b. COUNTY PG		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1717 Owens Rd 20745		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph R Sisson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST XXXXXX Alice May Hardy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-44-2701		17. INFORMANT ADDRESS Ronald E Shaffer Same as 13						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic Breast Cancer**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June , 19 84 , to Oct. 9 , 19 84 , that (I) (we) last saw the deceased alive on Oct 9 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harvey J Kato MD				DEGREE MD		22c. DATE SIGNED 10/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY J KATO MD				22e. ADDRESS 6525 Belmont Rd Hyattsville Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/84		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD	
24. FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home MD				25a. DATE REC'D. BY REGISTRAR OCT 17 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Julia T. Shaffer		2a. DATE OF DEATH MONTH DAY YEAR 10 25 84		2b. HOUR 9:20a _M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 16, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. CITY OR TOWN CHARLES		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE RT#1 BOX 225 20695		13e. Brookwood Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no None					
16b. SOCIAL SECURITY NO. 207-07-5897		17. INFORMANT ADDRESS Marie Brinson - Brookwood Dr., White Plains,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cachexia & Debilitation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Biliary Carcinoma & Liver Metastases</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins. 6 mins. 6 mins.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypothyroid - mild.</u>									
19a. DATE OF OPERATION -- --		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -- --		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) -- --					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>82</u> to <u>10/25</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/25</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard A. Farson, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 10/25/84				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Farson, M.D.		22f. ADDRESS 9401 Indianhead Hwy Ft. Wash., Md. 20744							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/30/84		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harrisburg Dauphin Co. Pa.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc.		ADDRESS 6633 Old Alexander Ferry Road Clinton, Md.		25a. DATE REC'D. BY REGISTRAR OCT 30 1984		25b. REGISTRAR'S SIGNATURE <u>Richard A. Farson</u>			

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TO THE DIRECTOR, BUREAU OF REVENUE
FROM THE COMMISSIONER, BUREAU OF REVENUE
SUBJECT: [Illegible]

[Illegible body text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 4 9 5

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marion S. Shelton			2a. DATE OF DEATH MONTH DAY YEAR 10-30-84			2b. HOUR 1 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-8-10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nurs. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	
12b. KIND OF BUSINESS OR INDUSTRY BELTS, MD.		12c. DEPT. OF AGRICULTURE					
13a. STATE Md.		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 5800 63rd AVE 20737							
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD SANDERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-09-6021		17. INFORMANT ADDRESS ROBERT W. SHELTON (SAME AS #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleed, Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive heart failure, Parkinson's disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> 19 <u>84</u> to <u>PRESENT</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Luis A. Casas</u>		DEGREE (COVERED) ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-30-1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS A. CASAS FOR DR. G. COMPTON		22e. ADDRESS 14201 LAUREL AC DR #221 LAUREL MD 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE OCT. 30, 1984		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G. Co. MD.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS 20737 RIVERDALE, MD.		25a. DATE REC'D. BY REGISTRAR NOV 0 2 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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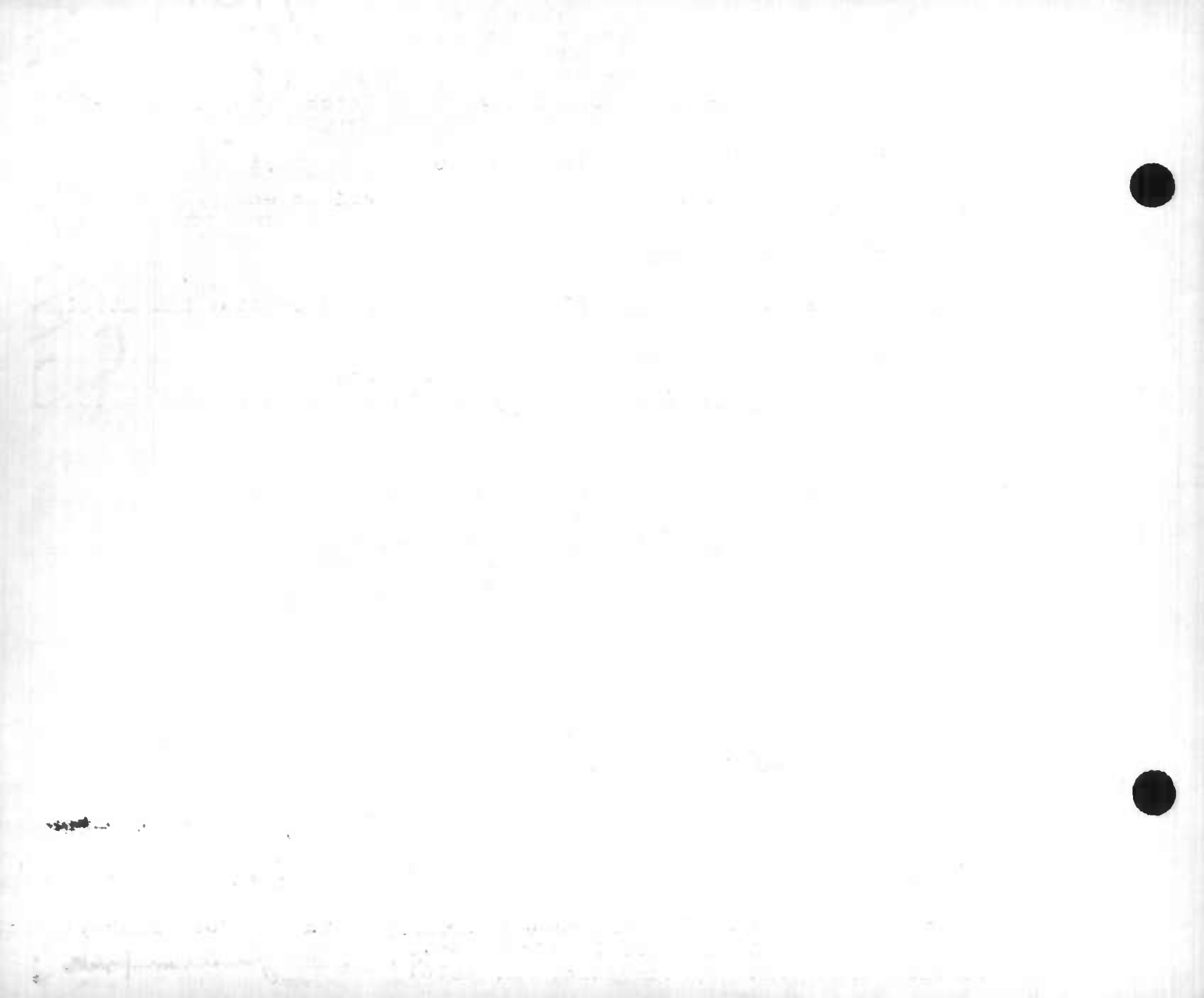
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WHICH ARE NOT IN THE
LIST OF THE OTHERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Mary Ruth Shenberger						2a. DATE OF DEATH MONTH October DAY 28 YEAR 1984		2b. HOUR 9:55p_M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 12 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5400 Decatur St. 20781	
14. FATHER'S NAME FIRST Wallace MIDDLE LAST Reed						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-34-6961		17. INFORMANT (Husband) ADDRESS Raymond L. Shenberger Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma to Liver DUE TO, OR AS A CONSEQUENCE OF (b) Primary unknown DUE TO, OR AS A CONSEQUENCE OF (c) Organic Brain Syndrome										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1983 , 19 84 , to 1984 , that (I) (we) lost saw the deceased alive on 10/28 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert J. Gasch				DEGREE D.O. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/29/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. GASCH				22e. ADDRESS 4410 74th Ave Hyattsville D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/31/84		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery York		23d. LOCATION CITY OR TOWN COUNTY STATE York Pennsylvania			
24. FUNERAL DIRECTOR Francis Gasch's Sons 4739 Baltimore Ave Funeral Home P.A. Hyattsville, Md. 20781											
25. DATE REC'D. BY REGISTRAR NOV 02 1984 REGISTRAR'S SIGNATURE John Davidson											



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

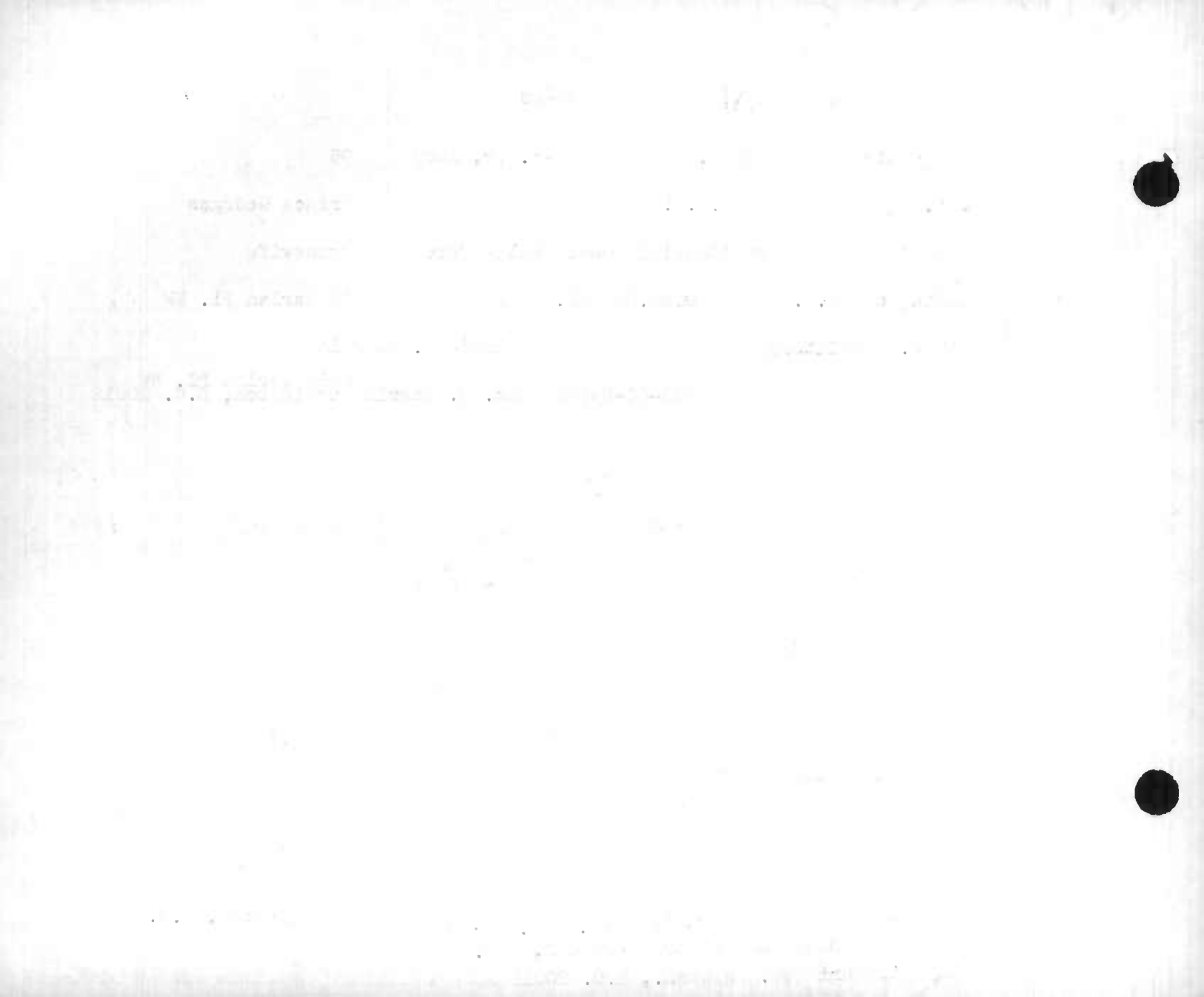
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen M Shepard			2a. DATE OF DEATH MONTH DAY YEAR 10-5-84		2b. HOUR 12:45A.M.			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Jan. 12, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods Health Care		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Washington D.C.			13c. CITY OR TOWN Dist. Of Col.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6614 Harlan Pl. NW 99999	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Mackintosh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie H. Diggela					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 023-01-0952D		17. INFORMANT ADDRESS Ann. S. Harris Washington, D.C. 20012				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) CHD: Angina Pectoris & MI APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1980 1980 1981								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Coronary arrhythmia, Chronic Renal Failure, Hypothyroidism								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 7/9/82 , 19____, to 10/5/84 , 19____, that (1) we lost saw the deceased alive on 10/3/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) not view the body after death.								
22b. SIGNATURE DBP Patrick MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/5/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GB Patrick MD		22e. ADDRESS 9221 Colesville Rd Silver Spring, Md 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/5/1984		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Med. School		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME ADDRESS Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Wash., D.C. 20011				25a. DATE REC'D. BY REGISTRAR OCT 8 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

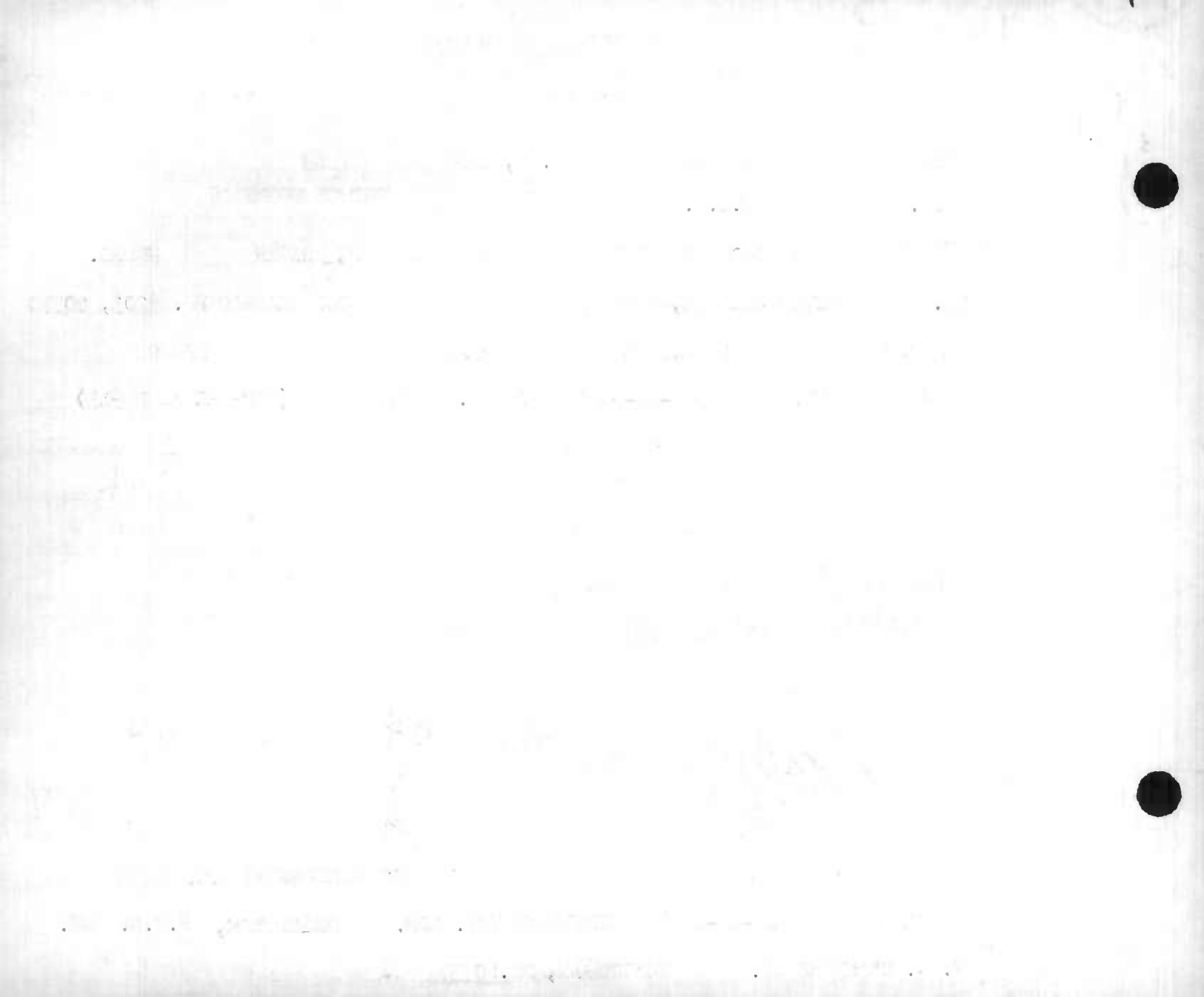


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISADORE SHREIBER										2a. DATE OF DEATH MONTH DAY YEAR 10 12 84		2b. HOUR 7:50PM M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV. 2, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.							
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUS DRIVER		12b. KIND OF BUSINESS OR INDUSTRY METRO.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN GREENBELT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8001 MANDAN Rd. #203, 20770					
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM SCHREIBER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN LACOCK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO WWII 579-14-9062		17. INFORMANT IDA R. SHREIBER				ADDRESS (SAME AS ITEM #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute renal failure</u> (c) <u>Arterial embolism</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>2 wks</u> <u>1 mo</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Aortobifemoral bypass</u>													
19a. DATE OF OPERATION 9/25/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atherosclerotic embolism				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) this hospital attended the deceased from <u>9/11/84</u> to <u>10/12/84</u> that (I) (we) last saw the deceased alive on <u>10/12/84</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>[Signature]</u>				22c. DATE SIGNED 10/13/84				22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. GOLDBERG M.D.					
22e. ADDRESS 2121 PENN AVE WASHINGTON D.C. 20037													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-17-1984		23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM VET. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM P.G.C. Md.							
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20		25a. DATE REC'D. BY REGISTRAR OCT 23 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 499	
1. FOR STATE REGISTRAR UNK.#84-85											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Karla A. Sliter						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 10-28 1984		2b. HOUR 6:19			
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH Jan. 18, 1967	6. AGE (IN YEARS) 17 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. DATE PRONOUNCED DEAD 10-28 1984						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD					
10. CITY OR TOWN OF DEATH Glendale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hillmeade Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY None				
13a. STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Glen Dale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 12301 Guinevere Rd. 20769					
14. FATHER'S NAME Gerald Anthony Sliter				15. MOTHER'S MAIDEN NAME Jane Ellen Whitlatch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-88-8492		17. INFORMANT Gerald A. Sliter		ADDRESS 12301 Guinevere Rd., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 6:07 P.M. 10-28 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject struck by train							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) tracks		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Hillmeade Rd., Glendale, Prince George's Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 10-29-84					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE Oct. 31, 1984		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.					
24. FUNERAL DIRECTOR NAME 9013 Annapolis Rd.		24b. ADDRESS Lanham		24c. CITY OR TOWN Lanham, Md.		24d. STATE Md.		25a. DATE REC'D BY REGISTRAR NOV 07 1984			
25b. REGISTRAR'S SIGNATURE <i>John T. R. R. R.</i>											

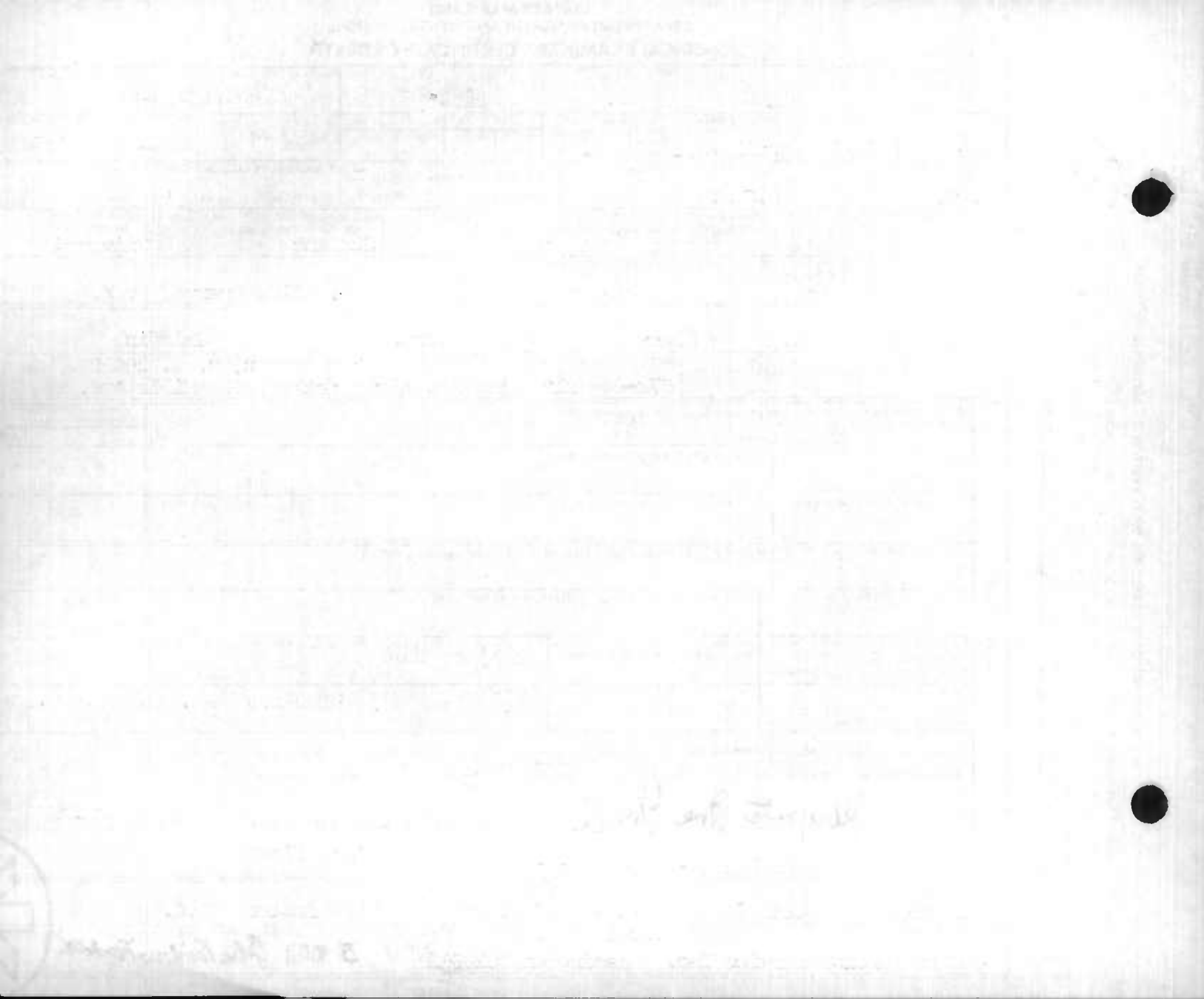
1. *Journal of the American Medical Association*, 1977; 237: 1001-1002.

WATSON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. MORTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHAM - 17
(VR A15 ME (5))
20M 4/82

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8500	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		X MONTH DAY YEAR		2b. HOUR	
MICHAEL P. SLUBY								10-26-84		19		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male		Black		April 23, 1966		18 YRS.						10-26-84 19 3:50A	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
D. C.		U.S.A.				Prince George's County MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Riverdale		Leland Memorial Hospital		Student		University							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
D.C.		--		Washington						2929 Mills Avenue, N. E.		9999	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Paul E. Sluby		Barbara Griffin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No		578-04-6919		Washington, D. C. 20018 Paul E. Sluby, father, 2929 Mills Ave. NE,									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 1AM 10-26-84 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) high school		21f. LOCATION (CITY OR TOWN, STREET, CROSS STREET, ETC.) Mt. Rainer Jr. High School Mt. Rainer, Md. STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		M.D.		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED					
Margarita A. Korell, M.D.		111 Penn Street						10-26-84					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Cremation		Oct. 30, 1984		J.Wm.Lee's Sons		Washington, D.C.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
McGuire Funeral Service, Inc., Washington, DC 20012		NOV 5 1984		Julie Swilley-Randall									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 472 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

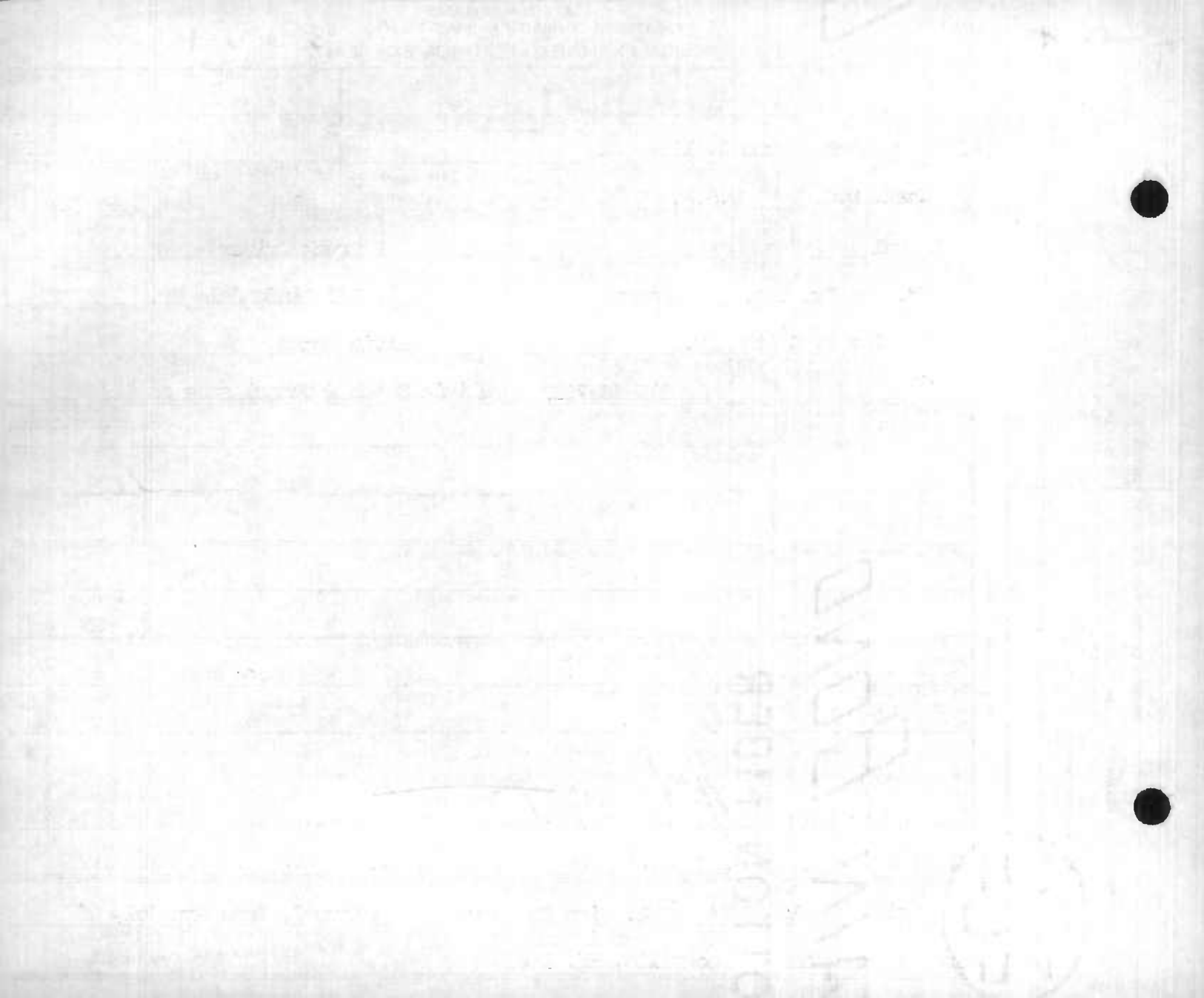
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO

1- FOR
STATE
REGISTRAR

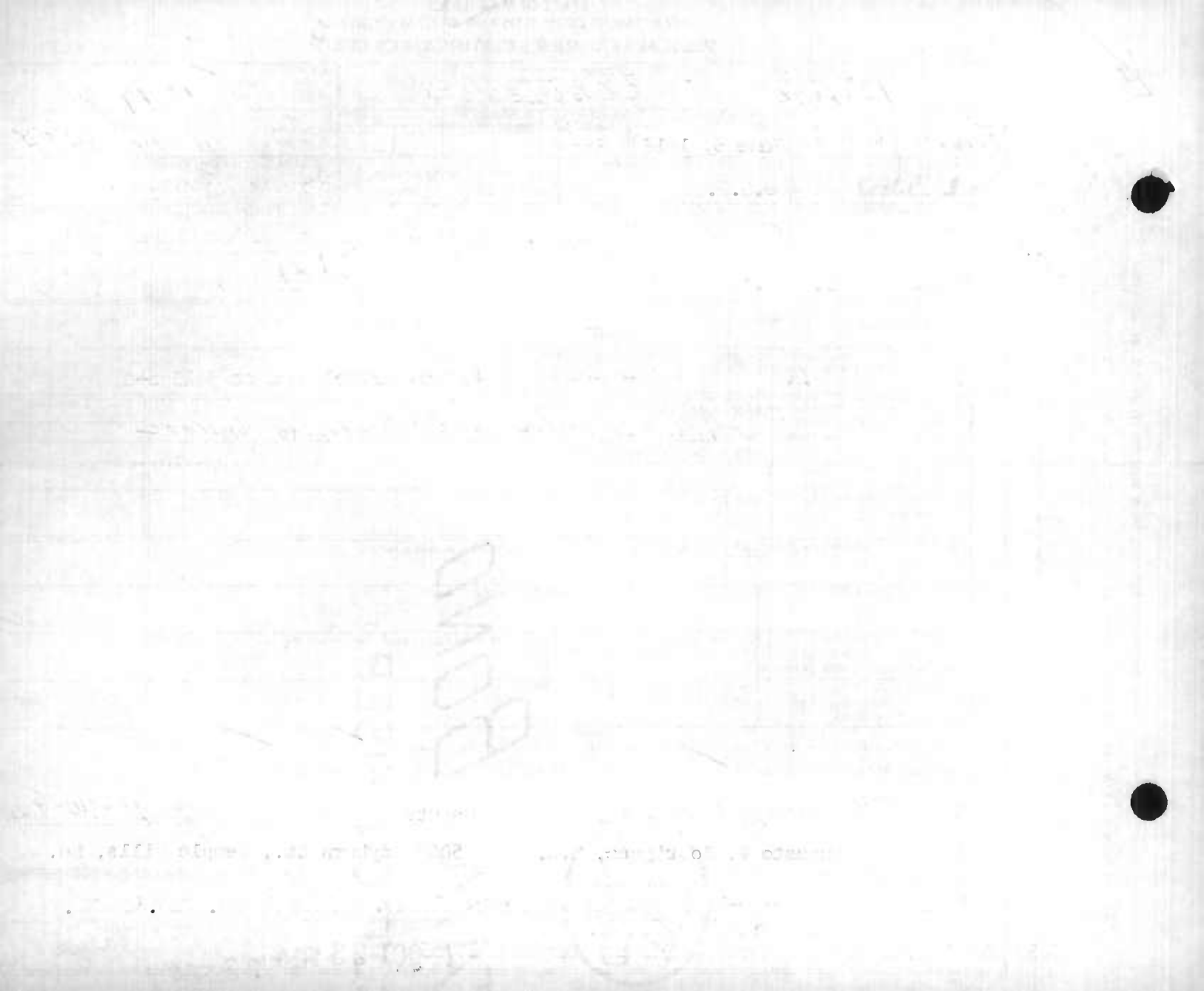
1 DECEASED NAME (TYPE OR PRINT)				2a DATE KNOWN OF DEATH				2b HOUR			
Charles E. Smith				X MONTH DAY YEAR 10-21 1984				4:35 a.m.			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	8 NEVER MARRIED	9 BALTIMORE CITY OR COUNTY OF DEATH			
Male	Black	June 8, 1956	28 YRS.	Wash. D.C.	U.S.A.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Prince George's County, MD			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Laurel		railroad tracks-mile post 23			Truck Driver						
13a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Md.				Pr. Geo.		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		8705 Lindendale Dr. 20707	
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME					
Charles E. Smith, Sr.						Olivia Jones					
16a WAS DECEASED EVER IN U.S. ARMED FORCES?				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				215-66-7023		Olivia Smith (Mother) same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Multiple Injuries											
8052											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY		21c HOW INJURY OCCURRED					
<input checked="" type="checkbox"/>				3:35xx 10-21 1984		subject sitting on tracks struck by train					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY		21f LOCATION					
				tracks		mile post 23, Prince George's Co., Maryland					
22a I certify that I took charge of the remains described above, held on											
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Dennis F. Smyth M.D.				Assistant				10-21-84			
EXAMINER'S NAME				ADDRESS							
(TYPE OR PRINT)				111 Penn St., Balto., Md. 21201							
23a BURIAL, CREMATION, REMOVAL				23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION		
Burial				10-25-84		Mt. Zion Cemetery			Laurel, Anne Arundel, Md		
24 FUNERAL DIRECTOR				25 REGISTRAR'S SIGNATURE							
George R. Snowden				Jana Davidson-Randall							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 M-1)
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 502	
1. DECEASED NAME (TYPE OR PRINT) ISABELLE F. SOBOLEWSKI <i>Isabelle F. SOBOLEWSKI</i>					2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY YEAR 10-19 1984					2b. HOUR M 54 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1916		6. AGE (IN YEARS) (LAST BIRTHDAY) 68 /RS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-19 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packer Potatoe Chips		12b. KIND OF BUSINESS OR INDUSTRY Lay's			
13a. STATE Maryland		13b. COUNTY Pr. Geo.'s		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5511 Kerby Road 20735			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Peters					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Shirley Howard Same as # 13 a-e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) Deputy M.D.				DATE SIGNED 10-20-84			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-23-1984		23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo.'s Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR OCT 23 1984				25b. REGISTRAR'S SIGNATURE <i>Davidson</i>			
25c. ADDRESS Old Alexander Ferry Road, Clinton Maryland 20735											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28503	
1. DECEASED NAME [TYPE OR PRINT] FIRST MIDDLE LAST Arsenio F. Soriano					2a. DATE OF DEATH MONTH DAY YEAR Oct. 25, 1984			2b. HOUR 2:55A			
3. SEX Male		4. RACE Filipino		5. DATE OF BIRTH MONTH DAY YEAR May 27, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philippines		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad		12b. KIND OF BUSINESS OR INDUSTRY Amtrak RR			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Viviano Soriano					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST George Soriano						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WWII					16b. SOCIAL SECURITY NO. 709-09-5367		17. INFORMANT ADDRESS Dr. George Soriano 624 Harry S. Truman Upper Marlboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocytic Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis to Bone DUE TO, OR AS A CONSEQUENCE OF (c) Ames Lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Parasites											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/10/84 to 10/25/84 , that (I) (we) last saw the deceased alive on 10/25/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) (did not know) the body after death.											
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/25/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ohannes Sahakian, M.D.				22e. ADDRESS 5632 Annapolis Rd., Bladensburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 Oct 84		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetary		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Md.					
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm				ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR 10/30/84					
				25b. REGISTRAR'S SIGNATURE [Signature]							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 2 8 5 0 4									
1. DECEASED NAME (TYPE OR PRINT) RUBY Lillian Sowers					2a. DATE OF DEATH MONTH DAY YEAR October 8, 1984			2b. HOUR 11:11 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 15, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
12. CITY OR TOWN OF DEATH Clinton		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Ctr.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietary Tech.		15. KIND OF BUSINESS OR INDUSTRY Chas. Co.			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Charles Waldorf		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 3031 E October Place 20601		
14. FATHER'S NAME FIRST MIDDLE LAST Flave H. Bailey					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Glidewell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 579-18-7900		17. INFORMANT (Son) Springfield, Missouri Gary E. Pennifill, 3421 N. Franklin				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>10-5-84</u> to <u>10-8-84</u> , that (I) (we) last saw the deceased alive on <u>10-8-84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If) (we) did not view the body after death.											
22b. SIGNATURE <u>Abdul H. Fadul</u>					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-9-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Hamid Fadul					22e. ADDRESS 202 La Plata Prof. Ctr. La Plata, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-11-84		23c. NAME OF CEMETERY OR CREMATORY Ash Camp Bapt. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Keyville, Charlotte, Va.				
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Md.					25a. DATE REC'D. BY REGISTRAR OCT 11 1984					25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendell	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at 410-396-1234.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GIUSEPPE SPADARO			2a. DATE OF DEATH MONTH DAY YEAR OCT, 24-1984			2b. HOUR 11.10 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 12 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88		7. IF UNDER 1 YEAR MONTHS DAYS YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NURSING CARE CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Self Employed		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Pr Geo		13c. CITY OR TOWN Berkshire		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2912 Viceroy Avenue 20747	
14. FATHER'S NAME FIRST MIDDLE LAST Spadaro			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gen. Del. Issue Md							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 16 7459		17. INFORMANT ADDRESS A Louis Galeano						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF (b) coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) cerebrovascular Disease 11/19/84 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/23 19 83 to 10/24 19 84 , that (I) (we) lost saw the deceased alive on 10/23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Don H. Yablonsky			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/25/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonsky			22e. ADDRESS 10800 Greenbelt Rd. 20706							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 Oct 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland				
24. FUNERAL DIRECTOR NAME Robert E Wilhelm			ADDRESS Suitland Maryland			25a. DATE REC'D. BY REGISTRAR 10/30/84		25b. REGISTRAR'S SIGNATURE John Davidson		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 5 0 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMORY H. STOWERS			2a. DATE OF DEATH MONTH DAY YEAR 10 30 84		2b. HOUR 10:54AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 29 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Paint Contractor		12b. KIND OF BUSINESS OR INDUSTRY Painting
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince George	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Zackie Pike Stowers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Davidson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. 234-38-6327	17. INFORMANT Audrey Jennings ADDRESS 8601 Temple Hills Rd. Temple Hills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain stem infarct DUE TO, OR AS A CONSEQUENCE OF (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (X) (this hospital) attended the deceased from October 26 , 19 84 , to October 30 , 19 84 , that (we) lost the deceased alive on October 30 , 19 84 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.					
22a. SIGNATURE Dennis F. Frank MD				22c. DATE SIGNED Oct. 30, 1984	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis F. Frank				22e. ADDRESS 1 Hosp. Drive, Cheverly, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/3/84	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Roanoke Roanoke Virginia
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Oxon Hill, Md.			25a. DATE REC'D. BY REGISTRAR NOV 5 1984		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 7

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Barbara Ann STRIETER			2a DATE OF DEATH MONTH DAY YEAR October 7, 1984			2b HOUR 11:00A.			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 14, 1922		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of P.G. County				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland			13b COUNTY Prince George College Park		13c CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS / ZIP CODE 3602 Marlborough Way 20740		
14 FATHER'S NAME FIRST MIDDLE LAST Charles Francis Rupertus			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith V. Smith			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT ADDRESS Louis S. Strieter Husband Same as 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophageal Carcinoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 1'84	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Electrolyte Imbalance, Hyponatremia, Hyperkalemia</u>									
19a DATE OF OPERATION 10/1/84		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal Carcinoma			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>9/27</u> , 19 <u>84</u> to <u>10/7</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Katherine M. Sanzaru, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10/7/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) KATHERINE SANZARU				22e ADDRESS 5804 Bal U. Ave, Hyattsville Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 10, 1984		23c NAME OF CEMETERY OR CREMATORY Maryland Veterans		23d LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Geo. Maryland			
24 FUNERAL DIRECTOR Francis J. Collins NAME ADDRESS 500 University Blvd., W. Silver Spring, Md.				25a DATE REC'D. BY REGISTRAR OCT 11 1984		25b REGISTRAR'S SIGNATURE G. J. Wilson-Randall			

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Charles Francis Rogers Fifth V. Smith

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

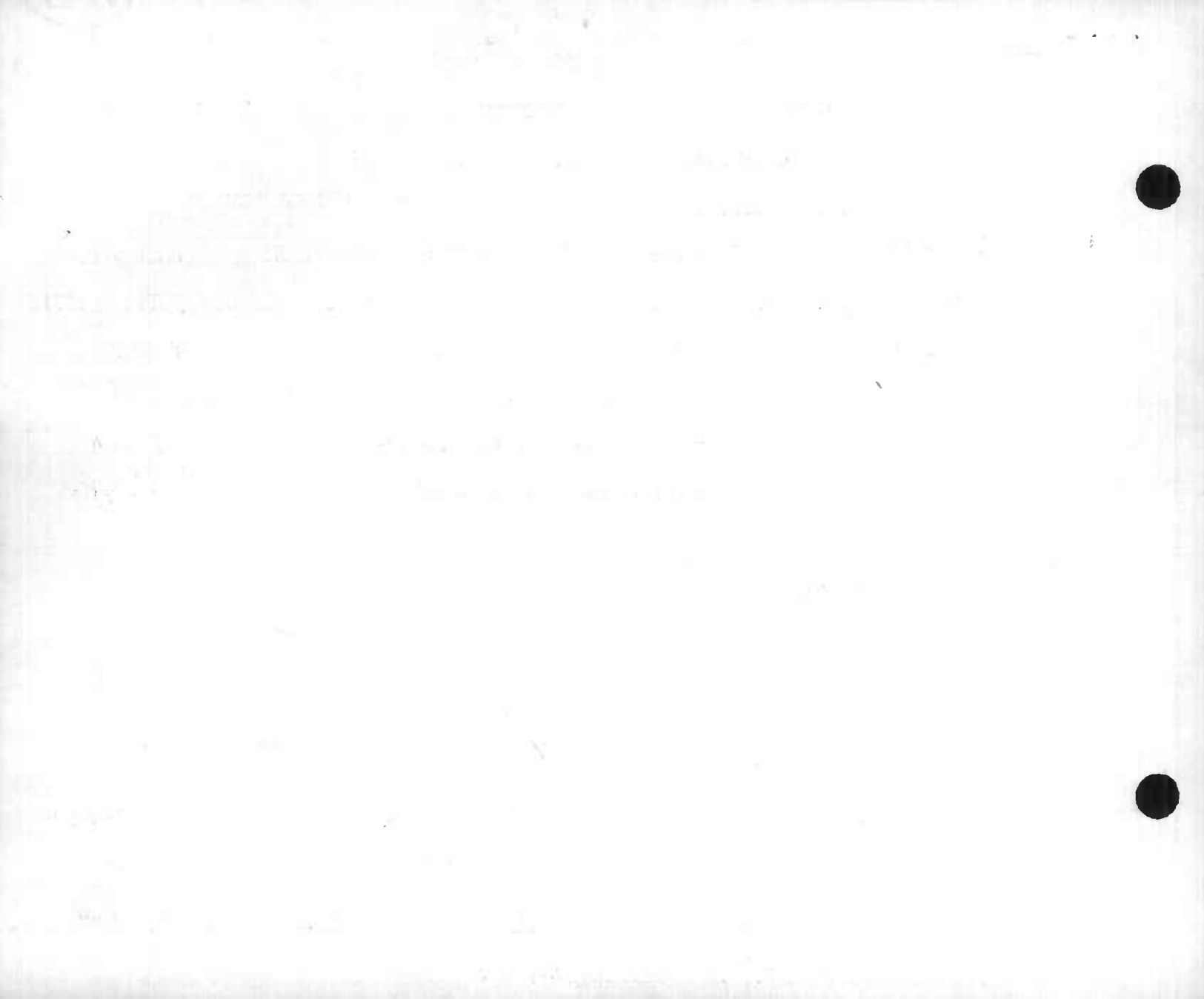
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN S SWEENEY					2a. DATE OF DEATH MONTH DAY YEAR 10 10 84			2b. HOUR 2:50 P M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEB. 20, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> XX		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY POST OFFICE			
13a. STATE MARYLAND					13b. COUNTY PR. GEO.		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD SWEENEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA STANLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-48-2337		17. INFORMANT ADDRESS WILLIAM E. SWEENEY SON - SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinson's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 1/2 yr</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Anemia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/10</u> 19 <u>84</u> , to <u>10/10</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Barbara Basuk</u> MD					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Basuk MD					22e. ADDRESS 5100 Auth Way, Suitland, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PR. GEO. MARYLAND			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25. DATE REC'D BY REGISTRAR OCT 18 1984			26. REGISTRAR'S SIGNATURE <u>John D. [Signature]</u>			
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.											

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8509

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Peter		October 8, 1984		1030	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
M	W	Jan 9 09 78	78		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Rhode Island		U.S.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Brentwood 4003		38th St. Apt. 1		Meter Reader	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Md		Prince Georges		20722	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
First Middle Last		First Middle Last		168-16-7068	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES?		17b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		WWII		John Leatherwood, W. Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
PART I DEATH WAS CAUSED BY:				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IMMEDIATE CAUSE (a)					
Acute Myocardial I.N.P.					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
Chronic Alcoholism					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John P. Pagan M.D.		Dys		Oct 9 1984	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
				25b. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		10/10/84		23d. LOCATION	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
Anatomy Board		Balto., Md.		Oct 18 1984 Julia Davidson-Rendall	

Very respectfully,
Yours truly,
[Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

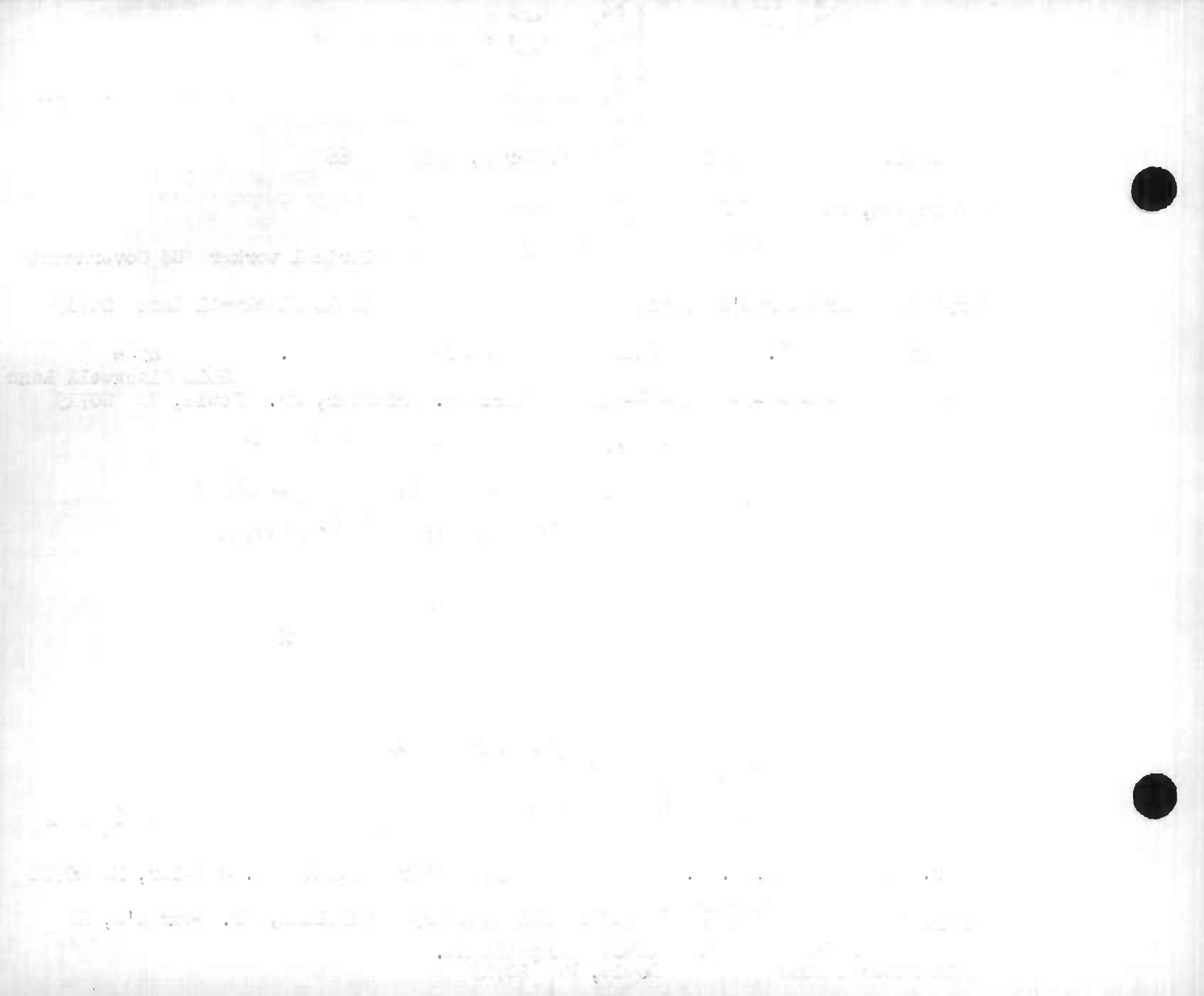
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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEANETTE M. TAYLOR			2a. DATE OF DEATH MONTH DAY YEAR 10-03-84			7b. HOUR 11 :35PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 2, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical worker		12b. KIND OF BUSINESS OR INDUSTRY US Government	
13a. STATE Maryland			13b. COUNTY Pr George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 12618 Blackwell Lane 20715									
14. FATHER'S NAME FIRST MIDDLE LAST James I. Miles			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie H. Hyde						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-7525		17. INFORMANT ADDRESS Alfred C. Priester, Jr. 12618 Blackwell Lane Bowie, MD 20715				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-20-84 to 10-3-84 , that (I) (we) lost saw the deceased alive on 10-3-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. Shah			DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mushtaq Shah, M. D.			22e. ADDRESS 4637 Eastern Avenue Mt. Rainier, MD 20712						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. George's, MD		
24. FUNERAL DIRECTOR NAME Beall Funeral Home			16000 Annapolis Rd. Bowie, MD 20715		25. DATE REC'D. BY REGISTRAR OCT 9 1984		26. REGISTRAR'S SIGNATURE John A. Davidson		

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 5 YEARS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10-2 19 84										2b. HOUR 5:51 P	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIVIAN T TAYLOR										2c. DATE PRONOUNCED DOA DEAD 10-2 19 84										2d. HOUR 5:51 P	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9-20-19		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.		7. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wrapper						12b. KIND OF BUSINESS OR INDUSTRY Giant Food					
13a. STATE Maryland										13b. COUNTY P.G.		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5422 Taussig Road 20710					
14. FATHER'S NAME FIRST MIDDLE LAST George M. Landis										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret T. Shugrue											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 579-18-0674				17. INFORMANT Mr. Dwight L. Taylor				ADDRESS Address Same as No# 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE August P. Rodriguez				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 10-2-84									
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct. Temple Hills, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 5, 1984				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland									
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland																					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Angelo Edward Terreri			2a. DATE OF DEATH KNOWN ESTI- MATED 8 Oct 20 1984		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov - 15 - 31 52	6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2b. DATE PRONOUNCED DEAD Oct 20 1984
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenleaf Laurel Beltsville Hosp		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Laurel			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plant manager		
14. FATHER'S NAME FIRST MIDDLE LAST Dominick Terreri			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Pennucci		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 137-20-2560		17. INFORMANT ADDRESS Nancy N. Terreri same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John R. Rogers		TITLE (SPECIFY) M.D. Dup		MEDICAL EXAMINER DATE SIGNED Oct 20 1984	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/24/84		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC.		23d. LOCATION Hanover, Morris Co. N.J.		25a. DATE REC'D. BY REGISTRAR OCT 24 1984	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

WINDMILL

2010 MOTION

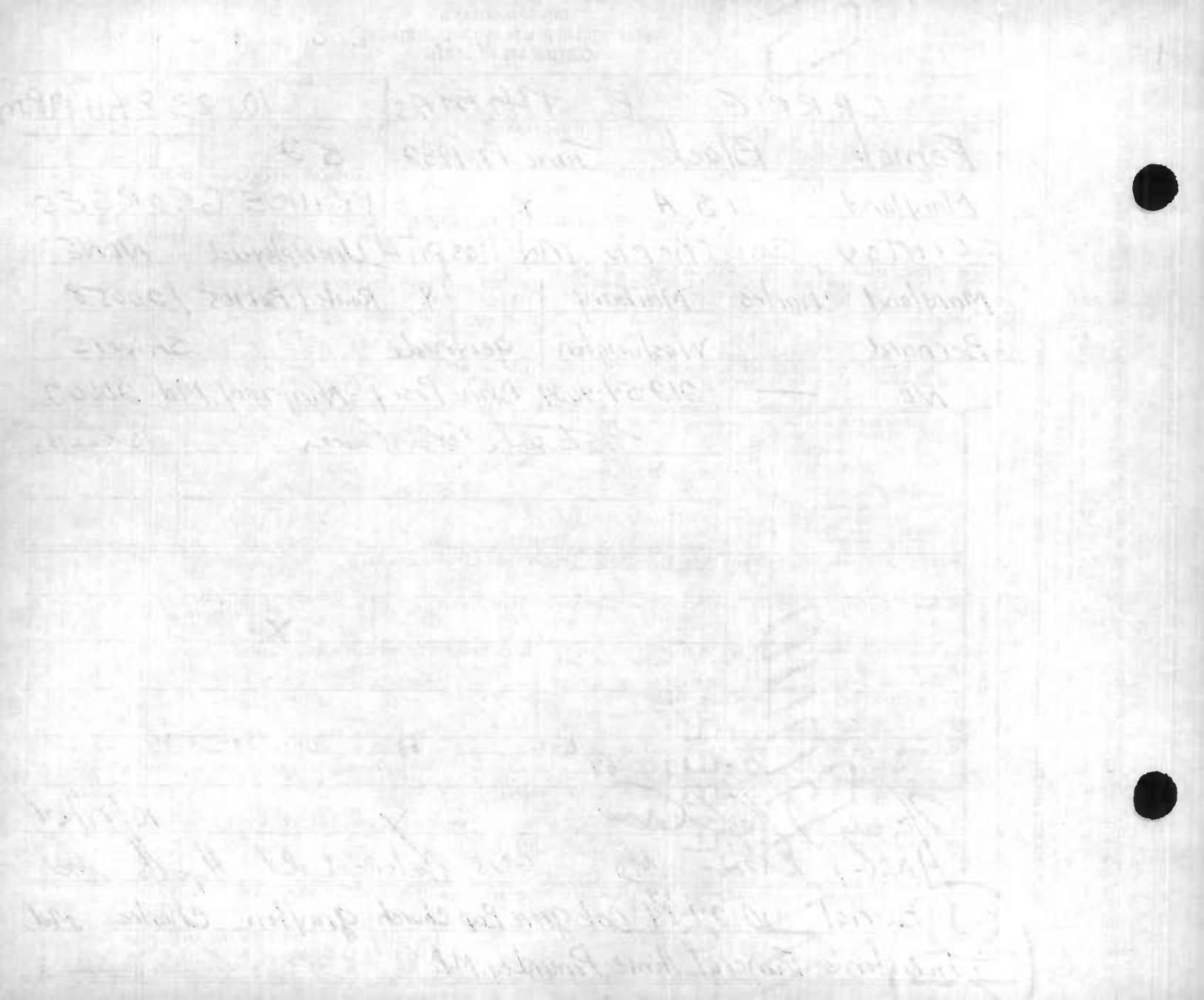
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2a should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or checked, there is any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 28513	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARRIE E THOMAS						2a. DATE OF DEATH MONTH DAY YEAR 10 23 84		2b. HOUR 11:19 P.M.	
2. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 17, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY NONE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Marbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 1 Box 105 / 20658			
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Washington				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Shivers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-54-4634		17. INFORMANT ADDRESS Diane Posey - Nanjemoy, Md. 20662					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Colon Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 1 , 19 83 , to Oct. 23 , 19 84 , that (I) (we) last saw the deceased alive on Oct. 23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harvey Katten MD				DEGREE				22c. DATE SIGNED 10/24/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY KATTEN MD				22e. ADDRESS 6525 Belcrest Rd Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-27-84		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Bap Church		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Charles Md.					
24. FUNERAL DIRECTOR NAME Thorton's Funeral Home				ADDRESS Pomonkey, Md.				25a. DATE REC'D BY REGISTRAR 06-29-84		25b. REGISTRAR'S SIGNATURE A. Davidson-Randall	

BP _____



Items 13a-13d per pg. 11/8/84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28514

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
Sylvanus						Thompson		10-12-84		PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	Black	6 1 42		42 YRS.				10-12-84		11:35	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Sirra Leone						Prince George's County		Cheverly		Prince George's Co. Hospital	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
unk.		unk.		unk.				YES <input type="checkbox"/> NO <input type="checkbox"/>		unk.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Unkn.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)		21f. LOCATION	
		10:45 PM 10-12-84		pedestrian struck by a vehicle				street		Kenilworth Ave/nr. Tuxedo Rd. P.G. County, Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Margarita A. Korell, M.D.		Assistant		10-14-84		Removal		10/25/84		111 Penn Street	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				Anatomy Board		Balto., Md.		OCT 31 1984		Julia Davidson Hordell	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



REPRODUCTION

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

28515

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen MIDDLE: S. LAST: Tilley			2a. DATE OF DEATH MONTH: October DAY: 17, YEAR: 1984			2b. HOUR: 9:15A. M.				
3 SEX: Female		4 RACE: Caucasian		5. DATE OF BIRTH MONTH: May DAY: 24 YEAR: 1909		6 AGE (IN YEARS LAST BIRTHDAY): 75 YRS		IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 72 HRS HOURS: MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY?: U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.				
10 CITY OR TOWN OF DEATH: Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher		12b. KIND OF BUSINESS OR INDUSTRY: Elm. Sch.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE: Maryland			13b. COUNTY: P.G.		13c. CITY OR TOWN: Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE: 16107 Kent Rd. 20707	
14. FATHER'S NAME FIRST: Eugene MIDDLE: L. LAST: Staples			15. MOTHER'S MAIDEN NAME FIRST: Mae MIDDLE: L. LAST: Fuller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No m			16b. SOCIAL SECURITY NO.: N/A		17. INFORMANT: Richard E. Tilley		ADDRESS: Same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>minutes</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Parkinson's Disease, malnutrition.</u>										
19a. DATE OF OPERATION:			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER):			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):		21f. LOCATION STREET CITY OR TOWN COUNTY STATE:					
22a. I certify that (1) this hospital attended the deceased from <u>Sept. 13, 1984</u> to <u>Oct 17, 1984</u> , that (we) last saw the deceased alive on <u>Oct 16, 1984</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE: <u>[Signature]</u>			DEGREE: <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED: <u>Oct 17, 1984</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT):			22e. ADDRESS:							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial			23b. DATE: 10/18/84		23c. NAME OF CEMETERY OR CREMATORY: Natl. Memorial Pk.		23d. LOCATION CITY OR TOWN: Falls Church STATE: Virginia			
24. FUNERAL DIRECTOR: FLECK FUNERAL HOME INC. NAME: Sandy Spring Rd. Laurel, Md.					25. DATE REC'D. BY REGISTRAR: Oct 18 1984		25b. REGISTRAR'S SIGNATURE: <u>[Signature]</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 8 5 1 6			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDDIE O! Brian TOWNSEND				2a. DATE OF DEATH MONTH DAY YEAR 10-11-84			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Freight Checker/Assn.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D. C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lee Townsend		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett Polk		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 242-44-8984		17. INFORMANT ADDRESS 5507 Tilden Road, Bladensburg, Maryland		17. INFORMANT NAME Carolyn M. Logan (daughter)			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE, AND ISCHEMIC DUE TO, OR AS A CONSEQUENCE OF CARDIO MYOPATHY (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 08/26, 19 84, to 10/11, 19 84, that (I) (we) lost saw the deceased alive on 10/11, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. A. Molavi, M.D.				DEGREE M.D.		22c. DATE SIGNED 10.12.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. Molavi, M.D.				22e. ADDRESS 6005 Landover Rd. Cheverly, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/15/84		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery, Brentwood, P.G. Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR LATNEY's Funeral Home NAME ADDRESS 3831 Georgia Ave. NW, Washington, DC 20011				25a. DATE REC'D. BY REGISTRAR OCT 18 1984		25b. REGISTRAR'S SIGNATURE P. G. Townsend-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and signed at the time of death.

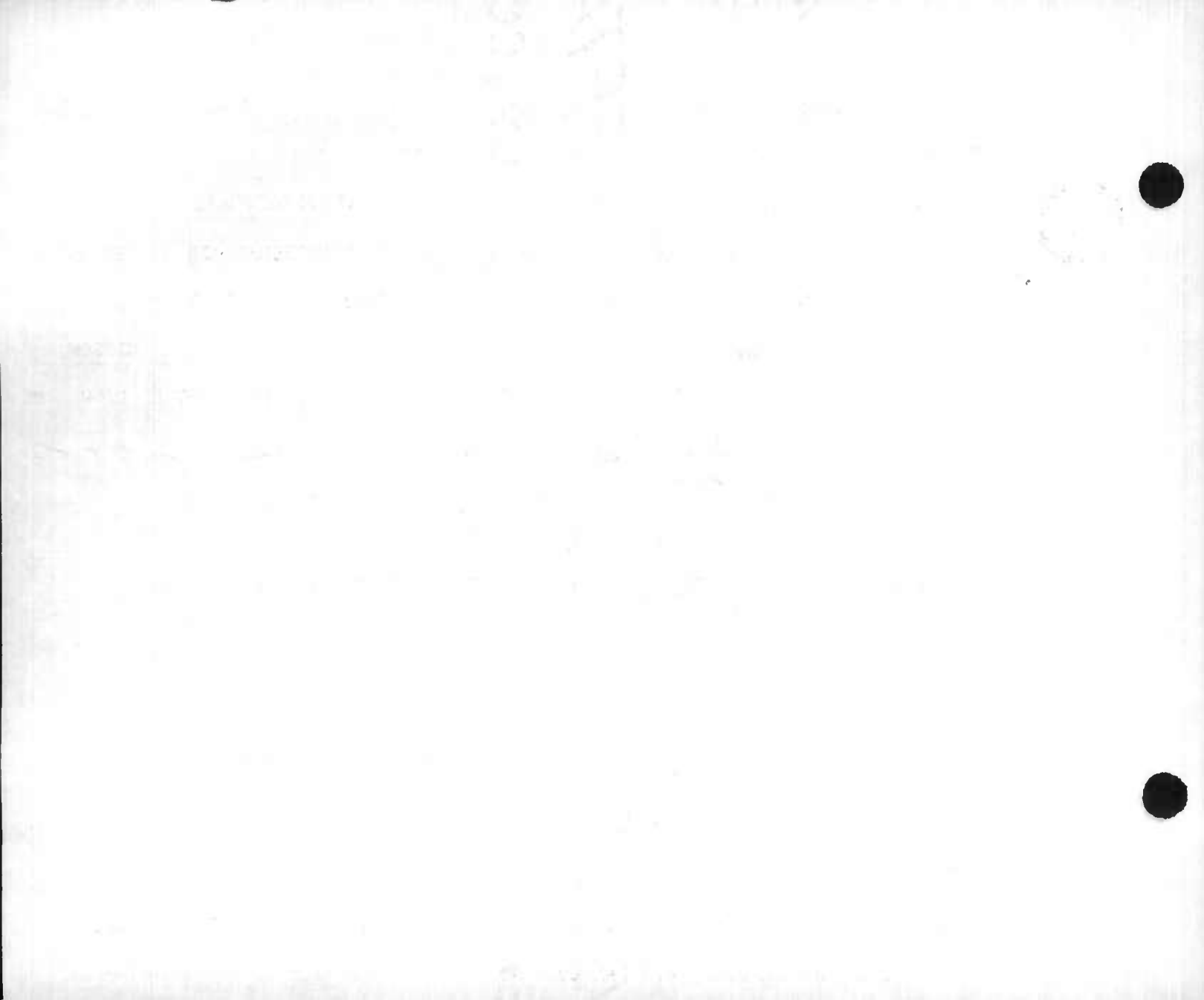
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28517

REG. NO.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		28517		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGIE M. TUCKER				2a. DATE OF DEATH MONTH DAY YEAR 10-21-84		2b. HOUR 7:30AM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 21 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSTRUCTIONAL AID		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. STATE MARYLAND		13b. COUNTY P.G.		13c. CITY OR TOWN BEAVER HGTS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALEC TRAVIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE GIBSON;		13e. STREET ADDRESS / ZIP CODE 1407 ELKWOOD LANE 20027			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-34-7960		17. INFORMANT ADDRESS ALAN S. TUCKER 4556 KENMOUNT RD LANHAM MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatocellular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ethanol Abuse</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Anemia, Occult Gastrointestinal Bleeding</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> 19 <u>84</u> , to <u>10/21</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>H. A. Wise</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/22/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. Wise		22e. ADDRESS Lanham, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/27/84		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD MARYLAND P.G.	
24. FUNERAL DIRECTOR NAME J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD				25a. DATE REC'D. BY REGISTRAR OCT 30 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendall	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 8 5 1 8 REG. NO.		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) CHARLES W. TYLER SR.								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 10-4 1984		2b. HOUR M 8:58 P PM
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR Jul. 15, 1907	6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 10-4 1984	7d. DATE PRONOUNCED DEAD 10-4 1984		7e. HOUR M 8:58 P PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.						
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS Hardware Distributor				
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13511 Tower Rd. 20613				
14. FATHER'S NAME FIRST MIDDLE LAST Steven Tyler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Randall				16. ADDRESS 13511 Tower Road Brandywine, Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-38-98634		17. INFORMANT Sarah J. Tyler		17b. ADDRESS 13511 Tower Road Brandywine, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER				DATE 10-4-84						
EXAMINER'S NAME (TYPE OR PRINT) AUGUSTO P. RODRIGUEZ, M. D.		ADDRESS 5009 RAYBURN CT. CAMP SPRINGS, MD 20748										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Nat. Memorial Park (Md.) Laurel, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>Bernardo O. Ames</i>		ADDRESS 8914 Quarry Road Manassas, Va. 22110				25a. DATE REC'D. BY REGISTRAR OCT 16 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

RE: [Illegible]

TO: [Illegible]

DATE: [Illegible]
BY: [Illegible]



RECEIVED
JAN 10 1964
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				28519			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Emma M Utterback				2a. DATE OF DEATH MONTH DAY YEAR 10 27 84		2b. HOUR 2:33 P M	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 22 11		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Riverdale		13e. STREET ADDRESS / ZIP CODE 4812 Tuckerman St. 20737	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Leedy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie H. Chapman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT (Husband) ADDRESS Herman E. Utterback (Same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION. DUE TO, OR AS A CONSEQUENCE OF (c) CARDIOGENIC SHOCK. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COMPLETE HEART BLOCK, HYPERCHOLESTEREMIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/25/84 to 10/27/84 , that (I) (we) lost saw the deceased alive on 10/27/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (do not) view the body after death.							
22b. SIGNATURE Arvind M. Mehta MD				DEGREE MD		22c. DATE SIGNED 10/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARVIND M. MEHTA				22e. ADDRESS 7100 BALTIMORE AVE. COL. PARK EAST WEST H MD 20740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/84		23c. NAME OF CEMETERY OR CREMATORY National Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Virginia	
24. FUNERAL DIRECTOR Francis Gasch's Sons 4739 Baltimore Ave. Funeral Home P.A. Hyattsville, Md. 20781				25. DATE REC'D. BY REGISTRAR 10/28/84			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DMMH - 17
 (VR A15 ME)
 20M 4/82

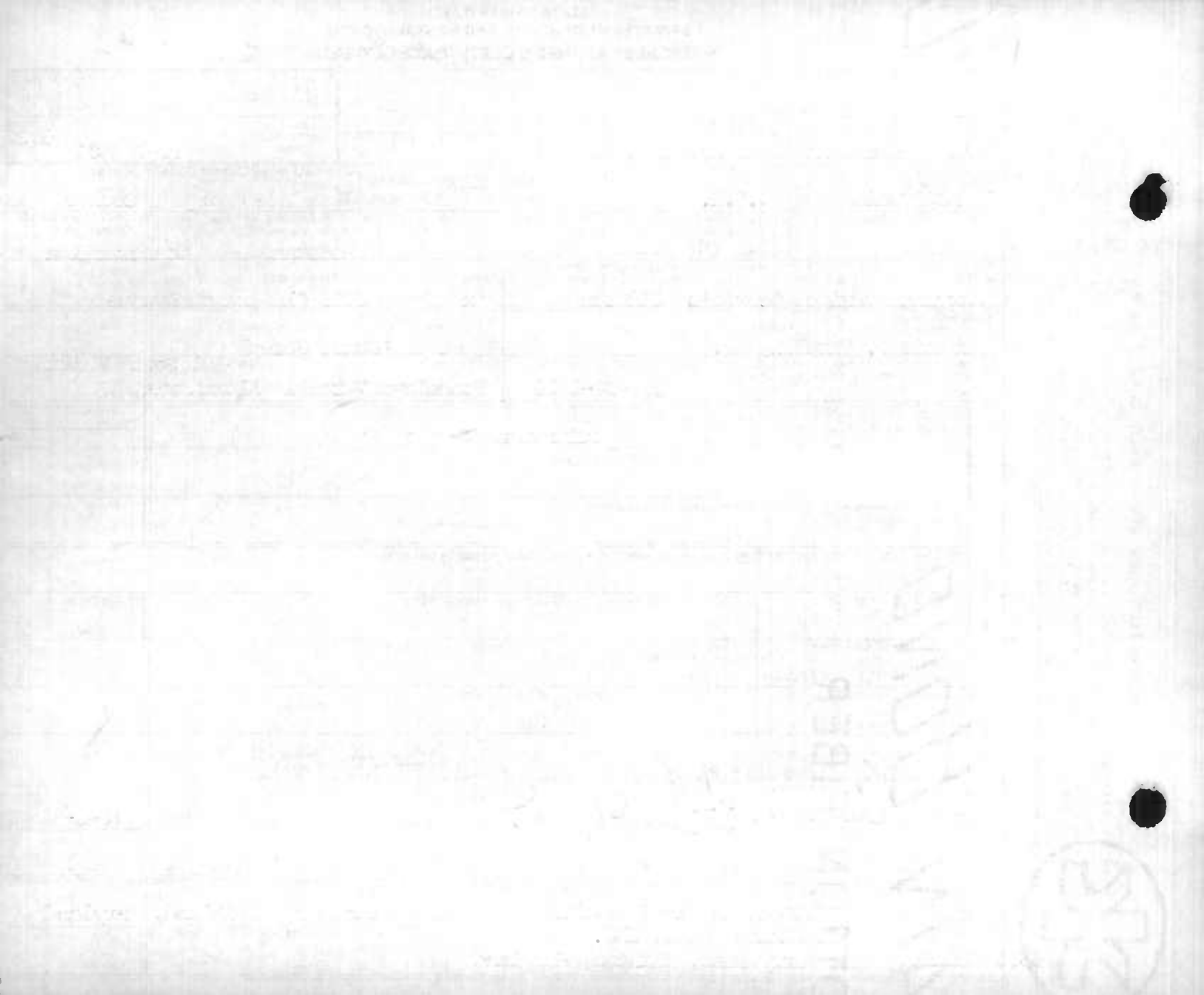
STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 5 2 0

REG. NO.

1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Francis P. Varelli, Jr.			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-6 1984			2b. HOUR M			
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 13, 1942	6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-7 1984			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8805 Old Branch Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rodsman		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 8805 Old Branch Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Francis P. Varelli, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Louise Joseph				ADDRESS 101 South Whiting	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Tondelayo Varelli		ADDRESS Alexandria, VA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER		DATE SIGNED 10-8-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 12, 1984		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. 6638 Old Alexander Ferry Road, Clinton, Maryland					25a. DATE REC'D. BY REGISTRAR OCT 15 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										28521			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST DORIS		MIDDLE L.		LAST VICK		2a. DATE OF DEATH		MONTH 10	DAY 10	YEAR 84	2b. HOUR 9:00AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD							
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Drug Store					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2368 Vermont Ave. #102 20785			
14. FATHER'S NAME FIRST MIDDLE LAST Raymond C. Gatts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Anderson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-36-2982		17. INFORMANT Mr. James H. Vick		ADDRESS Address Same as No #13e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>10-02</u> , 19 <u>84</u> , to <u>10-10</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10-10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Hernandez</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-11-84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.J. Hernandez MD		22e. ADDRESS Pr. Geo. Gen. Hosp. & Med. Ctr. Chev. Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 12, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland							
24. FUNERAL DIRECTOR NAME F. Casch's Sons F.H. P.A. Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR 15		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodriguez</u>									

BP

PROF. DR. V. J. J. VAN DER VLIET

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DHMH - 17
(VR A15 ME (5))
20M 4/82

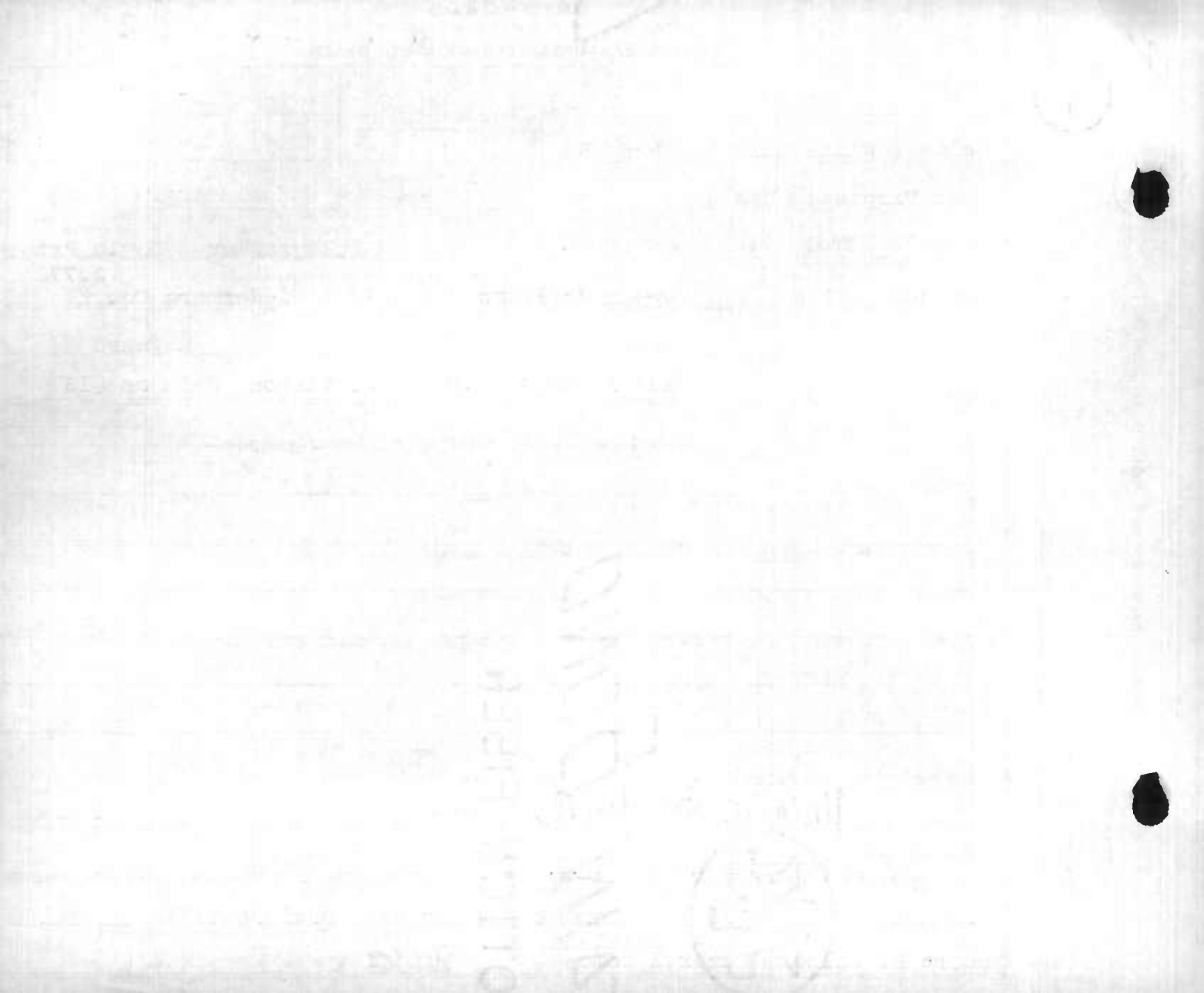
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 8 5 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		26. DATE OF DEATH		27. DATE OF ESTIMATION		28. DATE OF DEATH		29. DATE OF DEATH	
RUDOLPH		VALENTINO		VINSON				10-15-84		10-15-84		10-15-84		10-15-84	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. HOUR	
Male		White		July 16 1926		58 RS.						10-15-84		4:05 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED		12. BALTIMORE CITY OR COUNTY OF DEATH		13. BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia		USA				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Prince George's County		MD.	
14. UPPER OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY		18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19. STATE		20. COUNTY		21. CITY OR TOWN	
Upper Marlboro		1201 Windermer Ct.		Lithographer		Doyle Prtg				Maryland		P G		Upper Marlboro	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMATION		19. ADDRESS		20. DATE OF OPERATION		21. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
FIRST		LAST		YES		NO		YES		NO		YES		NO	
Vinson		Edna		Yes		22-22-9420		Barbara M. Vinson		Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		22. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
PART 1 DEATH WAS CAUSED BY:		Arteriosclerotic cardiovascular disease										26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												28. DATE OF OPERATION		29. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												32. DATE OF OPERATION		33. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												34. DATE OF OPERATION		35. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												36. DATE OF OPERATION		37. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												38. DATE OF OPERATION		39. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												40. DATE OF OPERATION		41. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												42. DATE OF OPERATION		43. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												44. DATE OF OPERATION		45. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												46. DATE OF OPERATION		47. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												48. DATE OF OPERATION		49. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												50. DATE OF OPERATION		51. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												52. DATE OF OPERATION		53. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												54. DATE OF OPERATION		55. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												56. DATE OF OPERATION		57. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												58. DATE OF OPERATION		59. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												60. DATE OF OPERATION		61. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												62. DATE OF OPERATION		63. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												64. DATE OF OPERATION		65. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												66. DATE OF OPERATION		67. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												68. DATE OF OPERATION		69. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												70. DATE OF OPERATION		71. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												72. DATE OF OPERATION		73. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												74. DATE OF OPERATION		75. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												76. DATE OF OPERATION		77. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												78. DATE OF OPERATION		79. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												80. DATE OF OPERATION		81. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												82. DATE OF OPERATION		83. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												84. DATE OF OPERATION		85. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												86. DATE OF OPERATION		87. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												88. DATE OF OPERATION		89. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
												90. DATE OF OPERATION		91. CONDITION FOR WHICH OPERATION WAS PERFORMED?	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having been any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28523			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Estella S. Wade				2a. DATE OF DEATH MONTH DAY YEAR October 16, 1984			
3. SEX Female				2b. HOUR 2:09P M			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 30, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Planning Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
13a. STATE Maryland				13b. COUNTY P.G. Co.			
13c. CITY OR TOWN Laurel				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 11752 S. Laurel Dr. 3A 20708				13f. ZIP CODE 20708			
14. FATHER'S NAME FIRST MIDDLE LAST Harry A. Sirbaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Drucilla Jolley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.				16b. SOCIAL SECURITY NO. 299-16-8256			
17. INFORMANT Ronald S. Wade				ADDRESS 36 S. Paca #615 Baltimore, Md. 21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>February</u> 19 <u>77</u> , to <u>Oct 16,</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>October 1</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>William A. Warren, MD</u>				22c. DATE SIGNED 10/16/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. A. Warren</u>				22e. ADDRESS 301 Annie George ST Laurel, Md 20702			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 10/17/84			
23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Co. Md.			
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707				25. DATE REC'D. BY REGISTRAR OCT 18 1984			
26. REGISTRAR'S SIGNATURE <u>Judson R. Riddle</u>				27. REGISTRAR'S SIGNATURE			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR ALL FILES, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

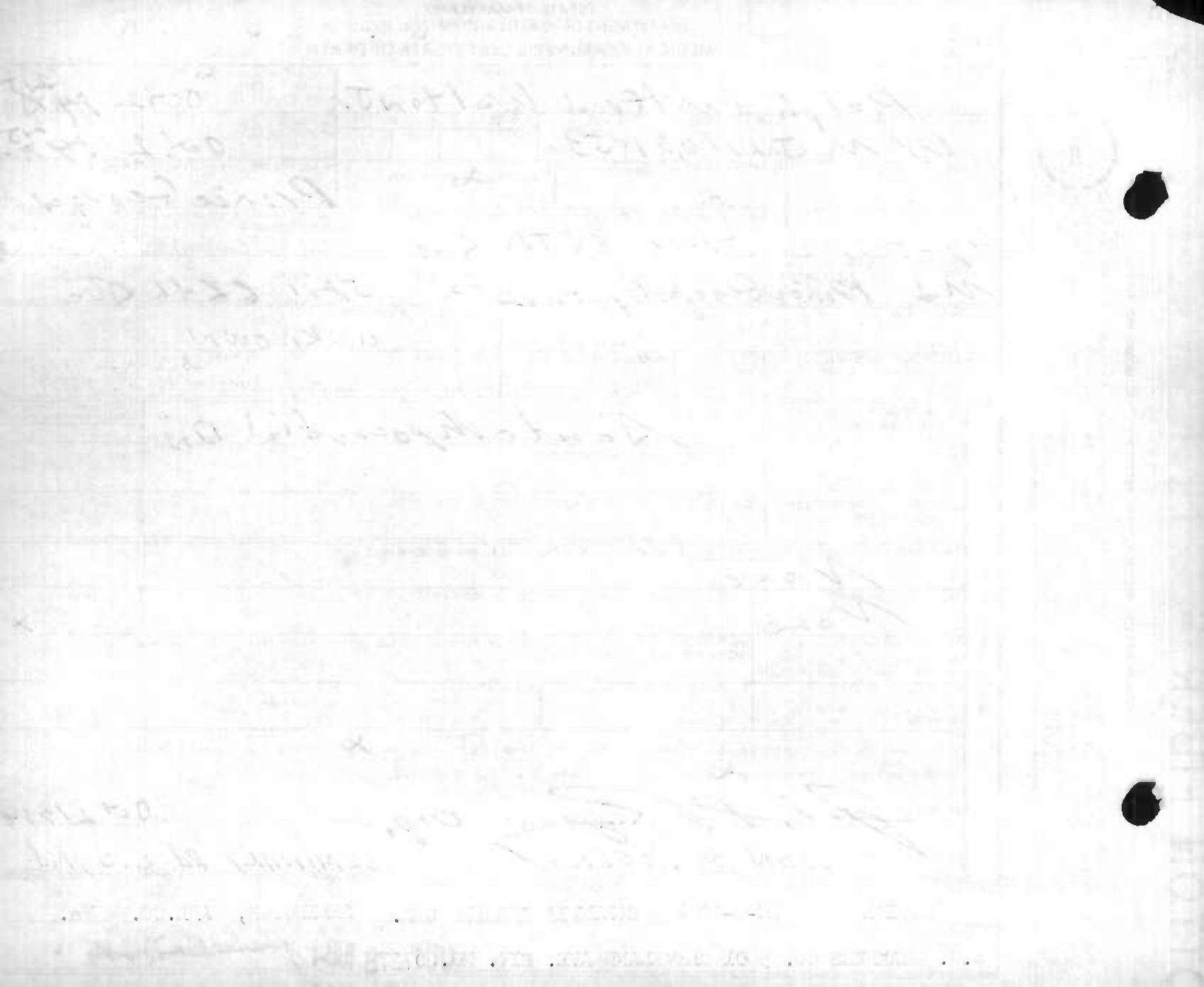
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

218524

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH		3. MONTH	
Ralph C. Walton Jr.								0022		1984	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR	14. MIN.
W	W	July 16, 1931	53 YRS.			0022	19	04	25	5	5
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New Jersey		U.S.A.				Prince Georges MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
RIVERDALE		5811 66th Ave				Psychologist		P.E. ASSO. FOR RETARDED CH.			
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		20737			
Md		Prince Georges		NO		5811 66th Ave					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Ralph W. Walton				UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		Korea		151-26-3103		Ms. Joan Walton, Riverdale, Md. 20737					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)											
Scrub Myocardial Dis.											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		CITY OR TOWN COUNTY STATE					
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
TITLE (SPECIFY)											
MEDICAL EXAMINER											
DATE SIGNED											
0022/22											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)											
BURIAL											
23b. DATE											
10-6-1984											
23c. NAME OF CEMETERY OR CREMATORY											
COLUMBIA GARDENS CEM.											
23d. LOCATION											
ARLINGTON, ARL. CO. Va.											
24. FUNERAL DIRECTOR											
NAME											
W.W. CHAMBERS CO. 5801 CLEVELAND AVE. RIV. MD. 20737											
25a. DATE REC'D BY REGISTRAR											
10-6-1984											
25b. REGISTRAR'S SIGNATURE											
John Davidson-Randall											



Released by Dr. Rodney to P.M.S. Copy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28525

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDWARD Allen WATSON Sr.			2a. DATE OF DEATH MONTH DAY YEAR 10/23/84			2b. HOUR 4:26 P M					
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Retail Store			
13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Marlow Heights		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4408 St. Barnabas Road 20748		
14. FATHER'S NAME FIRST MIDDLE LAST Wesley Watson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Skinner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----138-03-2942		17. INFORMANT ADDRESS 97 Garner Avenue Mayclaire Buschman Waldorf, Md. 20601						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL infarct DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10/23 1984 from 4:26 to 4:30 PM, that (I) (we) last saw the deceased alive on 10/23/84 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.											
22b. SIGNATURE M.P. Dolan M.D. for			22c. DEGREE PATHOLOGIST			22d. DATE SIGNED 10/25/84					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. R. GRACE			22f. ADDRESS 9131 Piscataway Rd., Clinton, Md. 20731								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-26-84		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery Waldorf, Charles, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Maryland			25a. DATE REC'D. BY REGISTRAR OCT 26 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell					

8

102

11th St.

Gen. Feb. 12, 1915

John

U.S.A.

Delaware

Dinner

Refill Stairs

20748

4008 St. Garrison Road

Union Heights

F.B.

Marion

May

Marion

Delaware

97 North Avenue

138-BJ-2942 Maryland

NO

10-26-84 St. Peter's Cemetery, Charles, Md.

Butler

10-26-84 St. Peter's Cemetery, Charles, Md.

Oct 26 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Postpaid may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

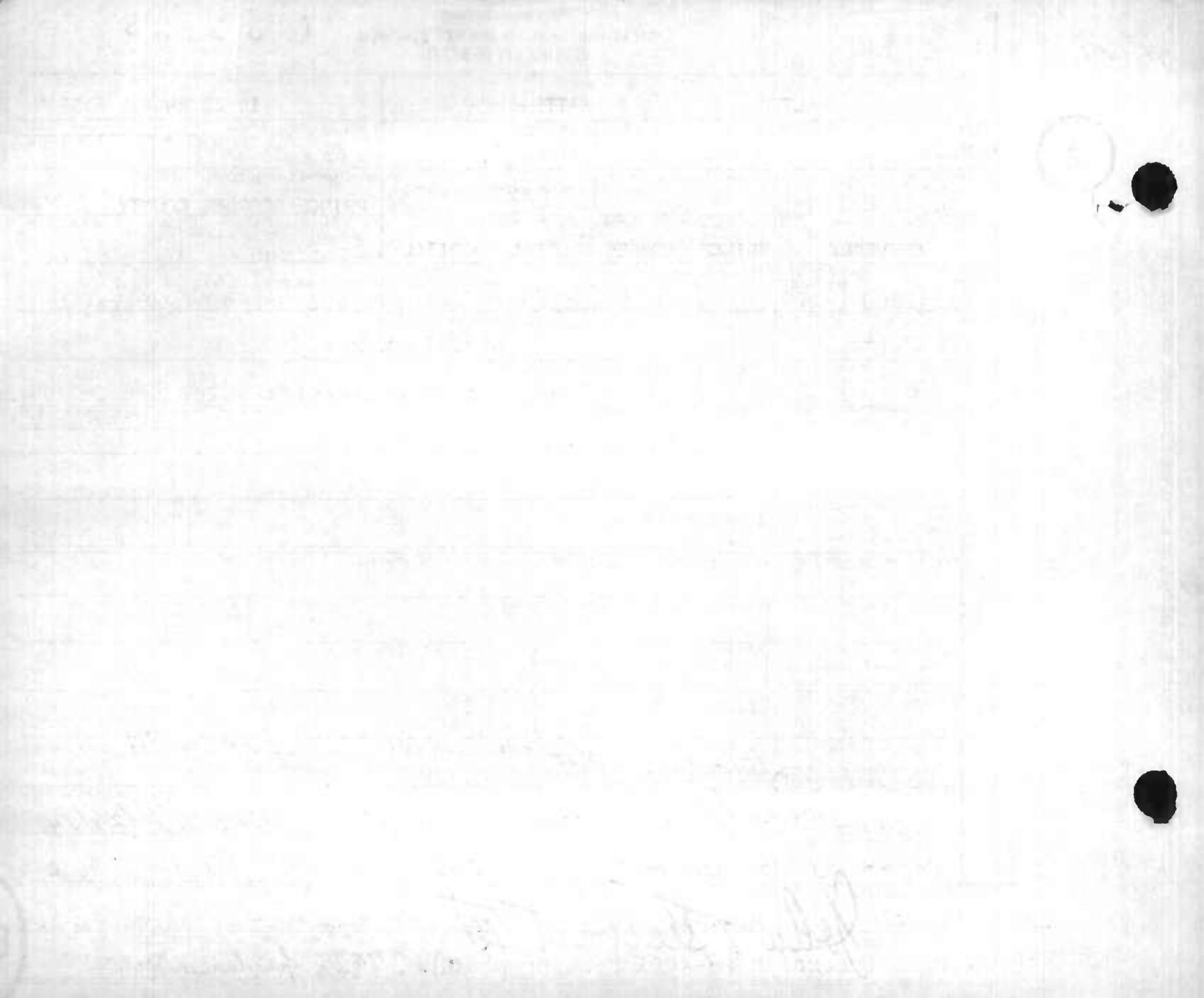
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

28526

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
WALTER WATTS		10 28 84		6 55AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))	8. IF UNDER 1 YEAR	
Male	Black	Oct. 9, 1919	65	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
South Carolina	USA		PRINCE GEORGES COUNTY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES GENERAL HOSPITAL		Retired		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland		PG	Greenbelt	YES <input type="checkbox"/> NO <input type="checkbox"/>	20770 7828 Hanover Parkway
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Sam Watts		Lucille Werks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		247 24 7650		Dorothy Watts-wife-7828 Hanover Pkw.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gram negative septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastric carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>84</u> , to <u>10/28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Mark D. Goldman MD</u>		22c. DATE SIGNED <u>10/28/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MARK D. GOLDMAN		6525 BELCREST RD. HYATTSVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Nov. 1, 1984		Fort Lincoln Cemetery	
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		NOV 7 1984		John Gordon Riddle	
Stewart Funeral Home-4001 Benning Road N.E.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				28527			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Gertrude N/M/N Welch</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>10-29-84</i>		2b. HOUR <i>10:00 M</i>	
3. SEX <i>Female</i>		4. RACE <i>Cau.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 13, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES COUNTY MD.</i>	
10. CITY OR TOWN OF DEATH <i>CLINTON MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SOUTHERN MARYLAND HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cashier</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Amusement Pk.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS <i>20640 Blair Road, Apt. 201</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Indian Head</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John A. Wenk</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Anna Jenkins</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>578-26-6678</i>		17. INFORMANT ADDRESS <i>Rt.#2 Box 77 Indian Head, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Cardio Respiratory Failure</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>HEVD, alcohol</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>aging</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>none</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10-27</i> 19 <i>70</i> to <i>10-29</i> 19 <i>84</i> , that (H) (we) lost saw the deceased alive on <i>10-28</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard Dobson</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10-29-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard Dobson, M.D.</i>				22e. ADDRESS <i>Brandywine, Maryland 20601</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-1-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Charles Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glymont, Charles, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Huntt Funeral Home, Waldorf, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 1 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Rodell</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2 8 5 2 8			
FOR 1 - STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA B. WHITE					2a. DATE OF DEATH MONTH DAY YEAR 10-18-84					2b. HOUR 6:10AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 14 18			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			12b. KIND OF BUSINESS OR INDUSTRY High School			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 118 Shuron Drive 20022	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Forest Hgts.									
14. FATHER'S NAME FIRST MIDDLE LAST John Gallington					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nonnie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unkn.				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ms. Elizabeth Stoddard 118 N. Huron Dr. Oxen Hill, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary Tract Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>9 days</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Bedridden - movement 2° old CVA</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>83</u> , to <u>10/18</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10/17</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <u>Don H. Yablonsky</u>				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/18/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonsky, MD						22e. ADDRESS 10300 Greenbelt Rd, Seabrook 20706							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 10/19/84		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.			25a. DATE REC'D BY REGISTRAR OCT 25 1984				
									25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

[Illegible text follows]

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RECEIVED
JAN 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 218529	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA M WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 09 25 84		2b. HOUR 9:46 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Private Ind.	
13a. STATE Maryland			13b. COUNTY P. Georges	13c. CITY OR TOWN Bladensburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bruce Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celestine French			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 131-01-5735		17. INFORMANT ADDRESS Peekskill, N. Y. Lynette M. Nick, Sister, 1109 Brown St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>end stage chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> 19 <u>84</u> to <u>9/25</u> 19 <u>84</u> , that (I) (we) lost <u>now</u> the deceased alive on <u>9/25</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Dennis F. Frank MD</u>		DEGREE MD		22c. DATE SIGNED 9/26/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DENNIS F. Frank MD</u>		22e. ADDRESS <u>1 Hosp. Drive Cheverly MD</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 27 Sept 84		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		23e. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 9 1984 <u>Sgt. Davidson-Randall</u>				
24. FUNERAL DIRECTOR W. Ernest Jarvis Co., Inc., Washington, D. C.						

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				218530 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DONALD R Williams				2a. DATE OF DEATH MONTH DAY YEAR 10/28/84			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 28 1934		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Budget Director		12b. KIND OF BUSINESS OR INDUSTRY Federal Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Georges 13c. CITY OR TOWN Ft. Washington 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET ADDRESS / ZIP CODE 806 Reid Terrace 20744			
14. FATHER'S NAME FIRST MIDDLE LAST Will Noah Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Boggess			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17. INFORMANT ADDRESS 806 Reid Terrace Ft. Washington, Md. NAME Janet C. Williams			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous Cell malignant cancer with cerebral metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) Donal R attended the deceased from June 19 84 to Oct 28 19 84 , that (1) (he) last saw the deceased alive on 10-28 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (I) did not examine the body after death.							
22b. SIGNATURE Kai-Yin Yeung		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yeung, MD				22e. ADDRESS 6525 Belcrest Rd #460 Hyattsville, 20782			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/84		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				25a. DATE REC'D. BY REGISTRAR OCT 31 1984		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	

George P. Kaine Funeral Home Oxon Hill, Md.
 6160 Oxon Hill Rd.

Burial 10/31/81 Resurrection Cemetery Clinton P.O. Maryland

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x x

x

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Yes

Unknown

102-0-7187

Janet C. Williams

806 Reid Terrace
 Ft. Washington, Md.

Will

Wash

Williams

Miss

Bowman

Maryland

Prince Georges Ft. Washington x

806 Reid Terrace

20111

Indyget Director Federal Gov't.

Kentucky

U.S.A.

x

July 28 1931

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Caucasian

Male

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										28531 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ed WILLIAMS III						2a. DATE KNOWN OF DEATH ESTIMATED 10-6-84		2b. HOUR 8:30 P			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1946	6. AGE (IN YEARS) LAST BIRTHDAY 37 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD 10-8-84		2d. HOUR 8:30 P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.					
10. CITY OR TOWN OF DEATH Suitland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence: 6559 Penna. Ave. #T-2				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disability Retired/Giant		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Prince Georges Suitland		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20746 Apt. T-2 Food 6559 Pennsylvania Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Ed Williams Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willia M. Coleman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-62-7603		17. INFORMANT 531 Shepherd Street, NW Willia M. Hollis (mother) Wash. DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pickwickian Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, FARM, ETC.]		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.				DATE SIGNED 10-8-84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/09/84		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory, Alexandria, Virginia				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home						25a. DATE REC'D. BY REGISTRAR OCT 18 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall			
26. ADDRESS 3831 Georgia Ave. NW, Washington, DC 20011											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				28532			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PHYLLIS M. WILSON				2a. DATE OF DEATH MONTH DAY YEAR 10 18 84			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 31, 1922		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 61	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Hugh T. Peck	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. Geo's. 13c. CITY OR TOWN Riverdale				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Warren Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Louise Landwehr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 315-18-3197		17. INFORMANT ADDRESS Richard Wilson 1866 Lindamoore Annapolis, Md. Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/17/84, 1984, to 10/18/84, 1984, that (I) (we) lost above, the deceased alive on 10/17/84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. P. J. A.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. P. J. A.				22e. ADDRESS P. G. C. HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10 Oct. 1984		23c. NAME OF CEMETERY OR CREMATORY Lakemont Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville Md.	
24. FUNERAL DIRECTOR NAME Howard Hale's Lanham Fun'l. Home				25a. DATE REC'D. BY REGISTRAR OCT 23 1984		25b. REGISTRAR'S SIGNATURE M. R. Pendall	
2013 Annapolis Rd., Lanham, Md. 20706							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28533

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ^{FIRST} OTHO ^{MIDDLE} E. ^{LAST} ELLSWORTH WINE, SR. OTH OTHO E. WINES		2a DATE OF DEATH MONTH DAY YEAR 10/27/84		2b HOUR 9:21 AM
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 19, 1919		6 AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY
10 CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b KIND OF BUSINESS OR INDUSTRY State Hwy.
13a STATE Maryland		13b COUNTY P.G.	13c CITY OR TOWN Upper Marlboro	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME ^{FIRST} Louis ^{MIDDLE} Washington ^{LAST} Wines		15 MOTHER'S MAIDEN NAME ^{FIRST} Ruth ^{MIDDLE} Helen ^{LAST} Stamp		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 579-07-1239		17 INFORMANT Upper Marlboro, Md. 20772 Otho E. Wines, Jr., P.O. Box 215

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>				<u>minutes</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>53 yr old chronic obstructive pulmonary disease; concern of the heart</u>				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>10-19</u> , 19 <u>87</u> , to <u>10-27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE <u>Dr. Almeida</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. ALMEIDA		22e ADDRESS <u>7201 W. Broad St. Clinton MS 39323</u>		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-20-84	23c NAME OF CEMETERY OR CREMATORY Md. Veteran's Cem	23d LOCATION CITY OR TOWN COUNTY STATE Cheltenham, P.G., Md.
24 FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md.		25a DATE REC'D. BY REGISTRAR OCT 30 1984	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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May 1, 1913

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 8 5 3 4

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Grace A. Witherow			2a. DATE OF DEATH MONTH DAY YEAR Oct. 5, 1984			2b. HOUR A 11:15 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Foreign Trade Bureau		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE DC		13b. COUNTY None		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Washington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Allison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 579-60-8802		17. INFORMANT ADDRESS Wilma W. Pechacek Same as item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Orbital</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arteriosclerosis</u>							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 30</u> 19 <u>84</u> to <u>Oct 5</u> 19 <u>84</u> . that (I) (the) lost saw the deceased alive on <u>Sept 30</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>James J. Foster MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED Oct. 5, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James J. Foster MD				22e. ADDRESS 916 19th Street NW Washington, D.C. 20006			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/84		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, MD	
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR OCT 11 1984			
25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>							

A

Dec. 1, 1904

James T. Foster, MD
Washington, D.C. 20002

Washington, D.C. 20002

James T. Foster, MD
Washington, D.C. 20002

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 8 5 3 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Hobert						7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10/21/84		7b. HOUR M <input type="checkbox"/> P <input type="checkbox"/>			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 29 1921	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 62	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/22/84		7d. HOUR P <input type="checkbox"/> M <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.					
10. CITY OR TOWN OF DEATH Aquasco		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 21122 Aquasco Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Watch Maker		12b. KIND OF BUSINESS OR INDUSTRY Jewelry			
13a. STATE Virginia		13b. COUNTY Lee	13c. CITY OR TOWN Jonesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. 4 Box 283A					
14. FATHER'S NAME FIRST MIDDLE LAST Hobert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Harris		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 223-26-4888		17. INFORMANT Herl Yeary		ADDRESS 199 Spruce Lane Mentor, Ohio 44060							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10/22/1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Pond		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 21122 Aquasco Rd., Aquasco, Pr. Geo., Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gregory R. Kauffman, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 10/23/84			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-26-84		23c. NAME OF CEMETERY OR CREMATORY Lee Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Pennington Gap, Lee, Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS Marzullo Funeral Service Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR Jul 25 1984		25b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

28536
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE OF DEATH		7b. HOUR	
Marshall Herman Zoellner				10 15 84		7:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
M		W		7 11 21		63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.				Prince Georges County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale		Leland Memorial Hospital		Police Officer		Police Dept.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
		Maryland		P.G.		Greenbelt	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Oscar Emil Zoellner		Helen Marie Heflin		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10-D Hillside Road 20770	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS Address Same as	
Yes-Navy		W.W.II		Mr. Carl W. Zoellner		No# 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Gastrointestinal bleeding		Gastrointestinal bleeding		Gastrointestinal bleeding			
Esophageal varices.		Esophageal varices.		Esophageal varices.			
Cirrhosis of the liver		Cirrhosis of the liver		Cirrhosis of the liver			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from saw the deceased or (my) (we) (did) (did not) see the body after death		22a. certify that (I) (this hospital) attended the deceased from saw the deceased or (my) (we) (did) (did not) see the body after death		22a. certify that (I) (this hospital) attended the deceased from saw the deceased or (my) (we) (did) (did not) see the body after death		22a. certify that (I) (this hospital) attended the deceased from saw the deceased or (my) (we) (did) (did not) see the body after death	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
ABRAHAM DABELA MD				10/16/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
		4404 Queensbury Rd. Riverdale MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Oct. 19, 1984		Maryland Veterans Cem		Cheltenham P.G. Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		OCT 22 1984		Julia Davidson-Randall			

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